The Trust for Developing Communities

The NHS, COVID-19 and Lockdown: The Black, Asian and Minoritised Ethnic Refugee Experience in Brighton and Hove

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Contents

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Executive summary

This report was produced on behalf of Sussex NHS Commissioners. The lead organisation was the Trust for Developing Communities. Partners contributed to the conducting interviews, focus groups, awareness of the online survey and developing the direction of the areas to be explored. The research partners were:

- Sussex Interpreting Services;
- Hangleton & Knoll Project;
- Voices in Exile;
- Network of International Women and
- Fresh Youth Perspective.

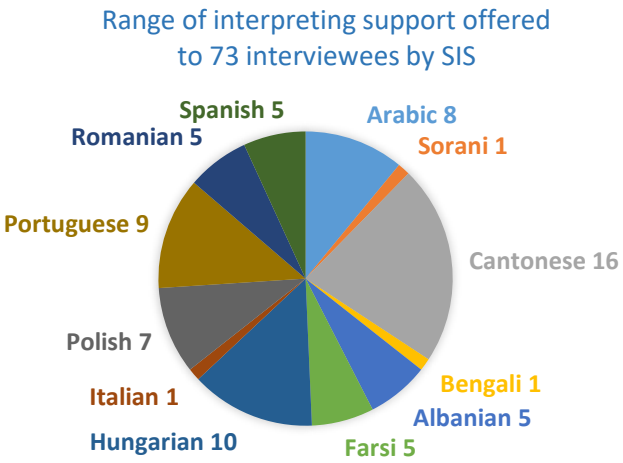
The agreed purpose of the survey was for Sussex NHS Commissioners to:

- Gather feedback from key BAME groups and communities, including Refugees and Migrants, on their **experiences of Covid-19**
- Gather feedback about the **information these groups and communities have received related to Covid-19**, and the degree to which this has been appropriate and useful
- Gain an increased **understanding of the issues and barriers related to accessing care**, whether Covid-19 related or other health care during the Covid-19 crisis period
- **Receive recommendations** that will ensure these communities are supported as we move to a recovery phase from Covid-19, and that can help shape our health and care services in the future

The research and the subsequent report explore Black, Asian and minoritised ethnic people and refugees (BAMER) experiences of COVID-19, the NHS, and access to the NHS and information about COVID-19. The study was widened to explore:

1. Experiences of lockdown;
2. Working during lockdown;
3. COVID-19 treatment and testing and
4. Sense of wellbeing.

When the UK went into lockdown on 23rd of March 2020, the everyday lives of the majority of the population changed. In doing so it exposed significant structural inequalities. This research involved 310 BAMER people in Brighton and Hove, who generously shared their experiences for this report. There were 56 different self-defined ethnicities in the research reflecting the diversity within Brighton and Hove, the reach and networks of the partnership. Females respondents were in the majority. People in the age category 35 – 54 were the highest number of respondents. Participants lived across all but one ward in the City. Most respondents when asked about religion or belief stated they had no religious affiliation, followed by Islam, Christianity and then Hinduism.



National analyses and surveys show that COVID-19 disproportionately impacts BAMER people. Evidence has been gathered by Public Health England[1], The Runnymede Trust[2], The Royal College of Nursing[3] and clinicians in Health Service Journal articles[4]. The Public Health England publication 'Beyond the Data', compares all-cause mortality in this year to previous years:

> *Comparing to previous years, all-cause mortality was almost 4 times higher than expected among Black males for this period, almost 3 times higher in Asian males and almost 2 times higher in White males. Among females, deaths were almost 3 times higher in this period in Black, Mixed and Other females, and 2.4 times higher in Asian females compared with 1.6 times in White females.* [5]

The Public Health England (2020) report explored the impact of COVID-19 on BAMER groups. They identified concern that the experience of racism, discrimination, stigma, fear and lack of trust among BAMER communities, including key workers within the National Health Service, increase vulnerability to COVID-19.

What we learnt

Contracting COVID-19. 13 per cent of all respondents believe that they have had COVID-19. An estimated further six per cent are unsure whether they have had COVID-19 because they had not been tested.

Working conditions and COVID-19. Many BAMER people who contracted COVID-19 did so as key workers. In Brighton and Hove, 31.3 per cent of the whole workforce are key workers[6]. The link between key workers and their households developing COVID-19[7] is well documented. This is significant because of disproportionate number of BAMER people working as key workers. BAMER women are particularly disproportionately represented in health and social care[8] key worker roles.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf
[2] https://www.runnymedetrust.org/uploads/Runnymede%20Covid19%20Survey%20report%20v3.pdf
[3] https://www.rcn.org.uk/news-and-events/news/uk-bame-nursing-staff-experiencing-greater-ppe-shortages-covid-19-280520
[4] https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article
[5] Ibid.
[6] https://www.ons.gov.uk
[7] https://www.runnymedetrust.org/uploads/Runnymede%20Covid19%20Survey%20report%20v3.pdf
[8] Ibid.

Another layer of complexity is the level of BAMER people subject to unfavourable working conditions, including zero-hour contracts, lack of Personal Protective Equipment (PPE) and high levels of risk[9]. 21 per cent of the BAMER key workers participating in this research felt that they were expected to take a higher risk compared to white colleagues. A further 35 per cent of respondents felt similarly but were less able to point to specific instances to evidence their perceptions. Studies show that BAMER people are more likely to experience unfavourable working conditions and less likely to receive sick pay. Research attributes these disparities to systemic racism and poorer experiences of healthcare.[10]

Information, communication and messaging. There was a high level of awareness of COVID-19 symptoms with only five per cent of interviewees expressing uncertainty.

The main sources of information were television, social media, friends and family, government briefings, local newspapers and voluntary sector groups. Respondents reported high levels of trust in the NHS and saw it as best placed to give out information around COVID-19.

Addressing barriers to accessing NHS care. Appreciation and praise for the NHS was high. 70 per cent (122) of BAMER interviewees and focus group respondents expressed an overwhelmingly positive response to the NHS. However, other BAMER people reported a negative or a mixed experience. Of the 175 interviewees and focus group respondents, 49 per cent (86) expressed a negative experience. Negative experiences included communication and language difficulties, cancellation of appointments often leading to poor health outcomes and perception of discriminatory treatment. Respondents reported that patients, particularly those with language needs, did not understand that they could contact GP Surgeries.

> *I have had very bad experiences. The services were terrible. I was mistreated with disrespect. I couldn't communicate at A&E and explain my issues because of lack of knowledge in English language and language barriers. They didn't use interpreting services to help me to explain my health condition. I felt so frustrated.*
>
> **Interpreting support provided to interviewee**

> *They didn't understand the nuanced messages and thought GP Surgeries were closed completely rather than just not seeing patients in person. Others didn't understand the text messages from GP`s or the long answerphone messages.*
>
> **SIS Linguists**

[9] https://www.rcn.org.uk/news-and-events/news/uk-bame-nursing-staff-experiencing-greater-ppe-shortages-covid-19-280520

[10] https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf
https://www.nursingtimes.net/news/coronavirus/workplace-racism-described-as-factor-in-bame-nurses-higher-virus-risk-16-06-2020/

COVID-19 and the lockdown experience

***Mental health*.** The emotions most commonly reported by survey respondents included a deep sense of anxiety; distrust; stress; conflict; confusion; fear and panic. This reflects ongoing UCL research findings,[11] showing increased levels of anxiety amongst BAMER individuals.

In the August 2020 report from the NHS Confederation 'Preparing for the Rising Tide'[12] there is a clearly articulated expectation of additional demand for mental health services, with particular concerns raised that the stark inequalities already faced by BAMER people in accessing mental health services will be further exacerbated.

Respondents in this research highlighted how the issue of difficulty in accessing physical health services had a negative effect on mental health.

> *I wasn't able to book appointments with my GP during lockdown. By not being able to see my GP I wasn't able to get a mental health medication.*
>
> ***Interpreting support provided to interviewee***

> *My daughter had toe injury and her toenail was infected. GP (Surgery name provided), proscribed her antibiotic, which didn't help so we took her to the hospital. They send us back home with nothing. Eventually, we went private and pay few hundreds of pounds for the procedure. It was important for us to get this done as soon as possible as our daughter already suffers from depression and has problem with self-harming… I had to live with tooth ache, my husband with backache also whole situation and lack of support has negative impact on my daughter's mental health.*
>
> ***Interpreting support provided to interviewee***

***Inequalities and poor outcomes in the face of COVID-19*.** This research concurs with the Runnymede Trust's *State of the Nation* report[13] which states that poverty, health inequality and poor housing conditions impact BAMER communities hardest. These communities can also be among the poorest socio-economic groups and are more likely to be at the frontline of this crisis in low-paid and precarious work.

The Marmot Review[14] highlighted that people living in deprived areas and those from BME backgrounds were not only more likely to have underlying health conditions because of their disadvantaged backgrounds, but they were also more likely to have shorter life expectancy as a result of their socioeconomic status.

> *Have needed help with finances. Friends and family abroad have sent them money. No recourse to public funds. My husband applied for benefits for first time in late February and now that is helping – but no allowance for me.*
>
> **Interviewee 127, a woman of Arab heritage**

Mitigating risk and negative impacts of lockdown. Interviewees and focus group participants recognised the need to find self-help strategies to mitigate possible negative impacts of lockdown and COVID-19. Many did so successfully. Others identified resources and support that would have been beneficial through lockdown. These included support to build confidence, maintain a routine and having someone to talk to.

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[11] https://www.ucl.ac.uk/news/2020/jul/levels-depression-and-anxiety-higher-amongst-those-bame-backgrounds-during-lockdown
[12] https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Report_Mental-health-services-NHS-Reset_FNL.pdf
[13] https://library.oapen.org/bitstream/handle/20.500.12657/22310/9781447351269.pdf?sequence=4&isAllowed=y
[14] https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Recommendations

1. Working conditions and COVID-19

Support and encourage employers to implement Equality Assessment Frameworks to incorporate all staff who are recognised as a Protected Characteristic under the Equalities Act 2010. This should include the local NHS as one of the most significant employers and contractors of BAMER people. Specifically, introduce BAMER-specific risk assessments in the workplace and review the use of zero-hour contracts in the light of COVID-19 risk. Measures such as reducing exposure to COVID-19 risk at work, offering the opportunity to work from home, ensuring access to adequate PPE and sick leave provision should be considered.

Employers should explore ensuring that workers are entitled to Statutory Sickness Pay (SSP). The Runnymede Trust identifies SSP as a tool to 'increase the chance of compliance with self-isolation and quarantining to minimise the spread of the coronavirus, and to shield vulnerable groups'[15]. This is particularly important for agency workers and those on zero-hours contracts within which BAMER groups are overrepresented. This recommendation should be seen alongside recommendation 4 of `Beyond the data: Understanding the impact of COVID-19 on BAME groups'.

> *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.*[16]

2. Information, communication and messaging

Provide unambiguous and simple information about the local health context. Clear signalling of messaging and guidelines is needed in a variety of formats. This information needs to be culturally appropriate and translated as reasonably required. Such resources would reassure BAMER people. Clarity and certainty are key because of the overwhelming amount of COVID-19 information and would help mitigate misinformation.

This report found that BAMER people have significant distrust of central government messaging around COVID-19. Messaging was perceived as contradictory to scientific evidence, hypocritical, and politically motivated. In contrast, the NHS was regarded as a trusted information source. NHS Commissioners can build on this trust. Understanding and use of the most effective communication channels for the target audience is crucial. NHS Commissioners can build on this trust by implementation of the World Health Organisation (WHO) Guidance and the five WHO Outbreak Communication Principles which are summarised as:

[15] https://www.runnymedetrust.org/uploads/Runnymede%20Covid19%20Survey%20report%20v3.pdf
[16] Public Health England (2020a) Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups, London. https://assets.publishing.service. gov.uk/government/uploads/system/uploads/ attachment_data/file/892376/COVID_stakeholder_ engagement_synthesis_beyond_the_data.pdf

- trust
- announcing early
- transparency
- listening
- planning

Communication resources should be tailored. The needs of different communities must be considered; especially the need to provide communications in languages and formats as required. Understanding and using the most effective communication channels is crucial.

3. Addressing barriers to accessing NHS care

Carry out Equality Impact Assessments on access to healthcare including supporting GP surgeries to target support to vulnerable patients through the Locally Commissioned Service, working with partners on the restore and recover agenda and seeking ways to mitigate the mental health impact of Covid-19.

This chimes with the Public Health England Report, recommendation 7, June 2020[17].

> *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.*

Fund and sustain meaningful approaches to tackling racial inequalities. Consideration should be given to creating a programme of training across the NHS in response to the recent discourse on race in the UK and in accordance with the Equalities Act 2010.

The programme of change should seek to address intentional, unintentional and casual incidents of discriminatory practices and behaviour towards people from BAMER backgrounds. This would improve NHS experience for BAMER people even when faced with communication issues or difference.

4. COVID-19 and the lockdown experience

Build closer, collaborative relations with the BAMER communities in Brighton and Hove.
Statutory bodies need knowledge of and insight into the communities they serve in order to gain a better understanding of those individuals. Participatory research with BAMER-led groups and organisations will help develop stronger and more meaningful relationships between health institutions and BAMER communities. These measures will also provide a strong platform to implement programmes to improve health outcomes and mitigate risk, being mindful of research and consultation fatigue.

[17] Public Health England (2020a) Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups, London. https://assets.publishing.service. gov.uk/government/uploads/system/uploads/ attachment_data/file/892376/COVID_stakeholder_ engagement_synthesis_beyond_the_data.pdf

5. **Promote health education by co-producing approaches with BAMER communities**

   Create an on-going dialogue with BAMER communities such as a forum that is able to respond to issues as they emerge. Fund, develop and implement culturally competent health education, risk reduction strategies and prevention campaigns with BAMER groups. Build relationships and trust to encourage positive engagements with the NHS.

6. **Further analyse survey data to learn more and explore intersectional experiences of life in lockdown**

   Whilst this research has explored a broad range of themes, time constraints and funding has meant that it has not been possible to undertake extensive analysis of the data collected for this study. The data could be further analysed to explore what it tells us about, for example, housing conditions, female perspectives, mental health and poverty. The intersection of gender, ethnicity and language barriers, coupled with the trauma of their past experiences could be further explored. The data could also be used to gather the self-help strategies developed by BAMER people during lock-down and would reveal the breadth of resourcefulness and resilience.

   It is recommended commissioners and all stakeholders read, understand and implement the recommendations of the report alongside national reports such as 'Beyond the Data: Understanding the impact of Covid-19 on BAME Groups Public Health Executive, June 2020), which give a national context. Particular attention in this report to be focused on Recommendations 2 – 7. The recommendations of that study, coincide, reflect and endorse findings and recommendations of this work.

Executive summary: Dr Anusree Biswas Sasidharan and Kaye Duerdoth

Introduction

This report was produced on behalf of Sussex NHS Commisioners by the Trust for Developing Communities and partners to explore experiences of Black Asian minoritised ethnic and refugee (BAMER)[18] groups' access and consumption of information about COVID-19, experience of the NHS, experience of COVID-19; the study was widened in scope to incorporate experience of lockdown, sense of wellbeing, experience of working during lockdown and treatment and testing of COVID-19.

The research, gathered through interviews, focus groups and surveys, paints a complicated picture of Black Asian and minoritised ethnic and refugee (BAMER) people in Brighton and Hove, which are made up of communities, individuals and households. People from BAMER communities range in:

- wealth and income
- education
- experience of the health service
- barriers faced in shielding
- occupation
- access to technology
- socio-economic background
- the gendered experience
- immigration status
- financial security
- experience of mental health
- living conditions
- neighbourhoods
- social networks
- access to appropriate PPE (personal protective equipment) at work
- if they are key workers
- literacy
- proficiency in the English language
- access to wider services.

What was shared however, was the recognition and acknowledgement that COVID-19 was impacting BAMER groups disproportionately compared to other groups.

In May 2020, a Royal College of Nursing survey[19] further revealed that BAMER nursing staff had less access to personal protective equipment (PPE) compared with white British colleagues.

Brighton and Hove
As of August 14th 2020, Government figures[20] cite that based on tests conducted in both NHS and commercial laboratory settings there have been 826 confirmed cases of COVID-19 in Brighton and Hove, which saw the reproduction number (known commonly as the 'R rate') for Brighton and Hove stand at 0.28[21] on August 14th. There were 163[22] recorded deaths in 2020 up until 31 July 2020 in Brighton and Hove which mention COVID-19 on the death certificate. More detailed statistical evaluation of the impact of COVID-19 on Brighton and Hove can be found elsewhere.[23]

[18] The term Black Asian and minoritised ethnic and refugee is used rather than 'Black Asian and minority ethnic' in order to stress the process of minoritising; that is, in societies where whiteness prevails, Black and minoritised ethnic communities are actively excluded and subordinated. This is processual. See also http://eprints.leedsbeckett.ac.uk/3625/3/Connecting%20%27Englishness%27%2C%20Black%20and%20minoritised%20ethnic%20communities%20and%20sport%20-%20a%20conceptual%20framework.pdf
[19] https://www.rcn.org.uk/news-and-events/news/uk-bame-nursing-staff-experiencing-greater-ppe-shortages-covid-19-280520
[20] https://coronavirus.data.gov.uk/
[21] https://coronavirus.data.gov.uk/
[22] https://new.brighton-hove.gov.uk/covid-19-key-statistics-brighton-hove/deaths-brighton-hove; https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard
[23] LG inform; NHS Digital; NHS England; Office for National Statistics; Brighton and Hove Healthwatch's The impact of COVID-19 on Brighton and Hove: a statistical evaluation; Brighton and Hove Council website,

Methodology

Data sources

This report has been developed from contributions from 310 individuals who lived in Brighton and Hove and who predominantly self-identified as Black Asian and minoritised ethnic and refugee. This cohort consisted of 13 people who took part in focus groups, 135 people who filled in a survey and 162 people who took part in interviews. The template for the survey, focus group template and interview guidance was developed by the author of this report with contributions from the partners to this report. The templates were shared with partner agencies in East Sussex and West Sussex. For purposes of anonymity, particularly if a person can be easily identifiable or if the issues are sensitive, interviewees and survey respondents' identifiable information will be kept to a minimum and broadened to obscure identity.

Online Survey

The survey was launched on the 14th of July and ran until the 31st of July and was completed by 135 individuals in Brighton and Hove. The survey used SurveyMonkey, an online survey tool, which consisted of six parts:

- 'NHS services';
- 'experiences of COVID-19';
- 'employment situation';
- 'working during COVID-19 lockdown',
- 'information and concerns' and
- 'about you' which captured diversity monitoring.

'Experiences of COVID-19' section was only activated if a person or their household had experienced COVID-19 and the 'working during COVID-19 lockdown' was only activated if a person had worked outside the home as an essential worker during lockdown. As not all people answered all questions (whether through choice or skipped past because they either had not worked in the lockdown or had not contracted COVID-19) the actual numbers of people alongside the percentages are given in parenthesis to give the most accurate and meaningful data. The survey had a series of multiple-choice questions and included free space to provide more qualitative answers.

The survey was self-selecting and anonymous and allowed for comments in free text, for those who wanted to comment further. It was open to anyone in Brighton and Hove and was publicised through voluntary and community channels who were encouraged to share it within their networks, social media platforms and through word of mouth.

Interviews

There were 162 structured interviews[24], the interviewer asked each respondent the same series of structured questions, unless they worked during lockdown or contracted COVID-19, where upon they were asked an additional set of questions that were asked to ensure consistency. The interview structure can be found in the appendix.

Focus groups

There were four focus groups comprised of 13 individuals that were conducted over a chat-based, online video and audio-conferencing platform. They followed the same structure as the interviews addressing:

- 'NHS services';
- 'employment situation';
- 'information and concerns' and
- 'about you'.

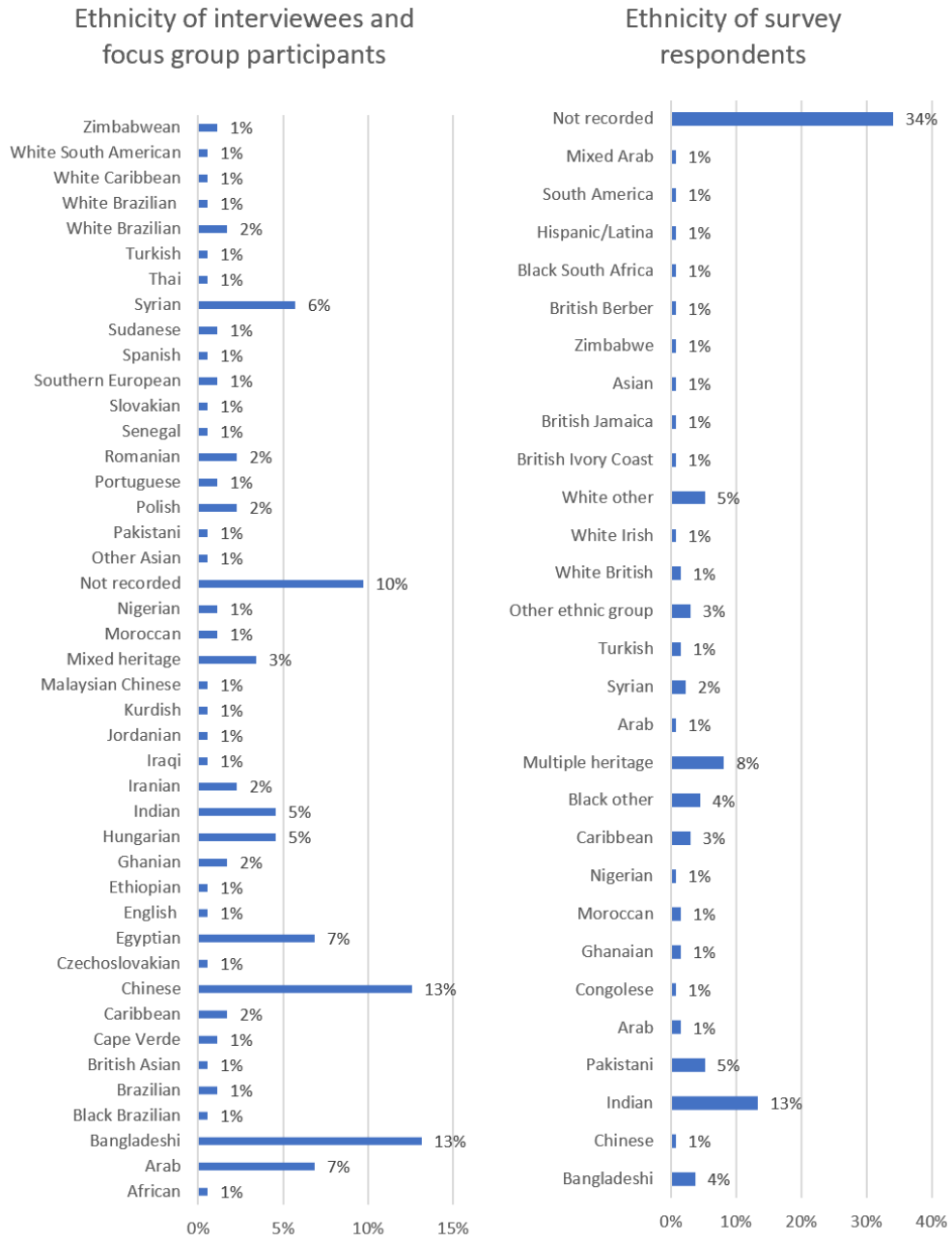
Sensitive topics such as 'experiences of COVID-19' and 'working during COVID-19 lockdown' were not discussed to ensure participants' privacy.

[24] Conducted by Trust for Developing Communities, Sussex Interpreting Services, Voices in Exile, The Hangleton and Knoll Project, The Network of International Women and Fresh Youth Perspectives.

Demographics[25]

Ethnicity

Of the 135 survey respondents, 85 per cent (111) identified with being BAMER [26], 66 per cent (89) chose to share what ethnic group they identified with and there were 28 different self-defined ethnic groups. The rate of non-recorded ethnicities was much higher amongst survey respondents at 34 per cent, in comparison with only ten per cent of interviewees and focus group participants who did not record ethnicity.



[25] Because of time restrictions and variance of data collection for interviewees and focus group participants demographics will only be broken down for ethnicity, gender and age.

[26] The remainder of people chose not to answer this question.

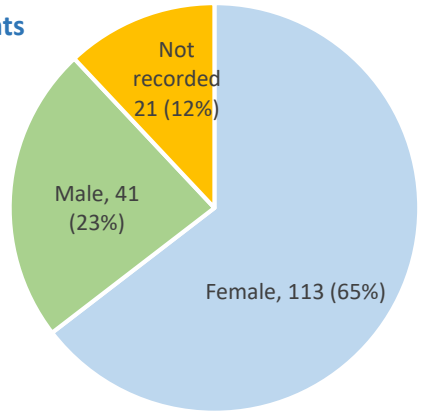
Out of the 310 participants in this study, there were 56 different self-defined groups, 43 of them represented within the 175 interviewees and focus group participants, and 28 different ethnic categories captured within the survey. The large number of self-defined groups attest to the diversity of ethnic groups in Brighton and Hove that exist in the city. The graphs above capture how both independent individuals and those who engage with partner organisations have participated in this survey. Those who filled in the online survey independently, identified as being of Indian heritage (at 13 per cent) followed by dual or multiple heritage (at eight per cent), other notably larger-sized groups included Pakistani and 'white other' groups (at five per cent) and Bangladeshi and 'black other' (at four per cent).

The biggest groups who took part in interviews and focus groups identified as Bangladeshi and Chinese which suggest that these are the most engaged with communities from partners organisations (at 13 per cent each), followed by Arab and Egyptian (at seven per cent each), Syrian (at six per cent), then Hungarian and Indian (at five per cent each) and mixed heritage (at three per cent), the rest of the groups made up one or two per cent of the participants.

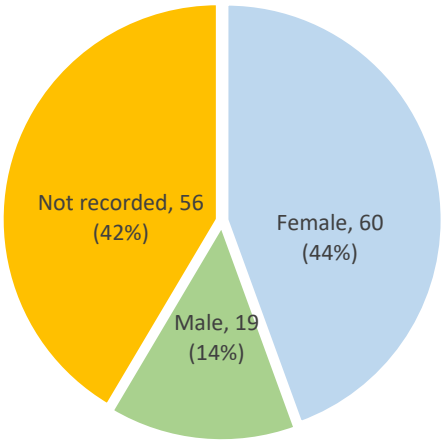
Gender

Females represented the majority of respondents in the self-selecting online survey, with 44 per cent identifying as female, compared with only 14 per cent of men and 42 per cent not disclosing their gender. For the interviews and focus groups, who engaged with partner organisations, women comprised of 65 per cent, compared with 23 per cent of men, with 12 per cent either not disclosing gender, or gender was not recorded. There is clear under-representation of men in this study as well as a significant non-disclosure of gender, particularly in the online survey.

Gender of interviewees and focus group respondents

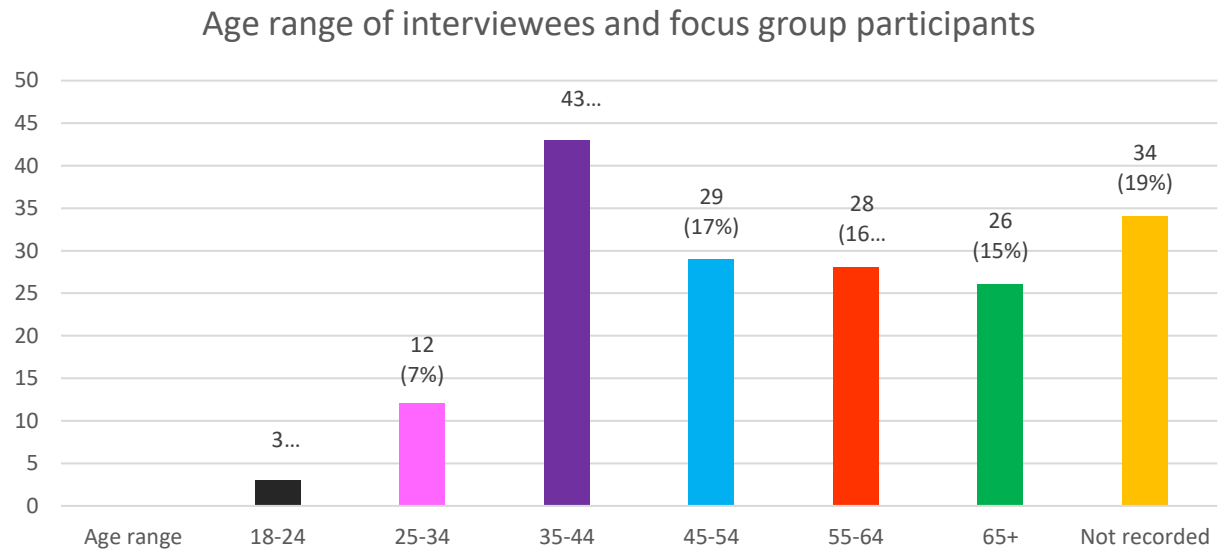


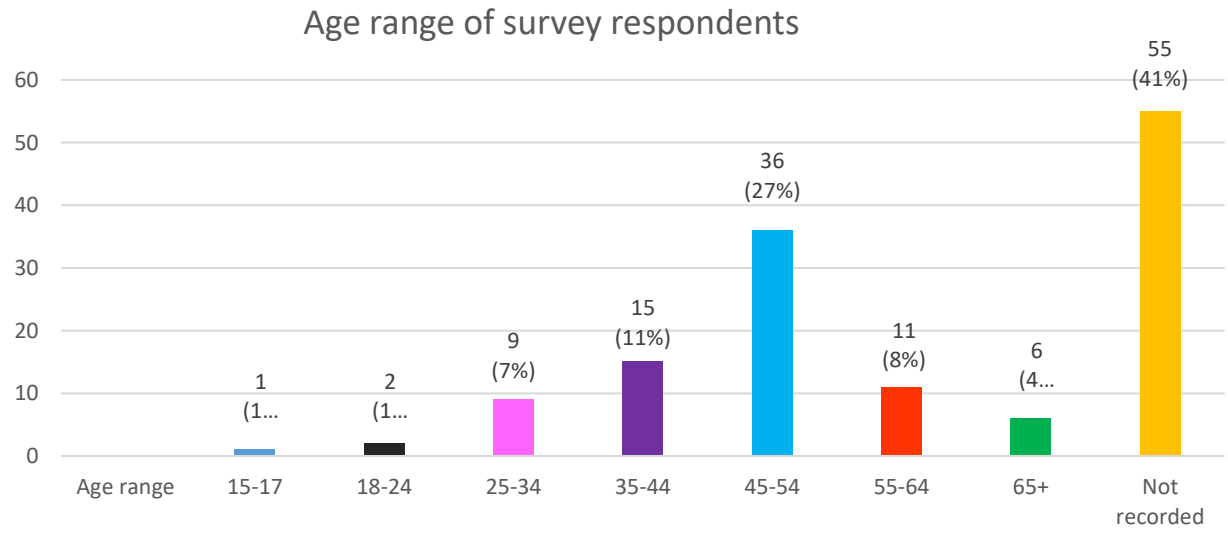
Gender of survey respondents



Age range of survey participants[27]

The largest age group cluster who disclosed their age was within the 35-44 and 45-54 age range making up 41 per cent of interviewees and focus groups respondents and 38 per cent of all participants in the survey. The 45-54 age range made up more than a quarter of survey respondents and the 35-44 age range were the most engaged with by partner organisations groups in terms of interviewees and focus group participants. People over the age 55 were much less likely to take part in the online survey, representing only 12 percent of participants, but significantly better represented in the interviews and focus groups at 33 per cent. Noticeably only two per cent of participants were under the age of 24, regardless of method used. Under 35s stayed identical at nine percent, regardless of method used, which is a very under-represented group in this study. The survey did not capture the age of 41 per cent of all participants, the interviewees and focus groups managed to half the number of unrecorded age range at 19 per cent.

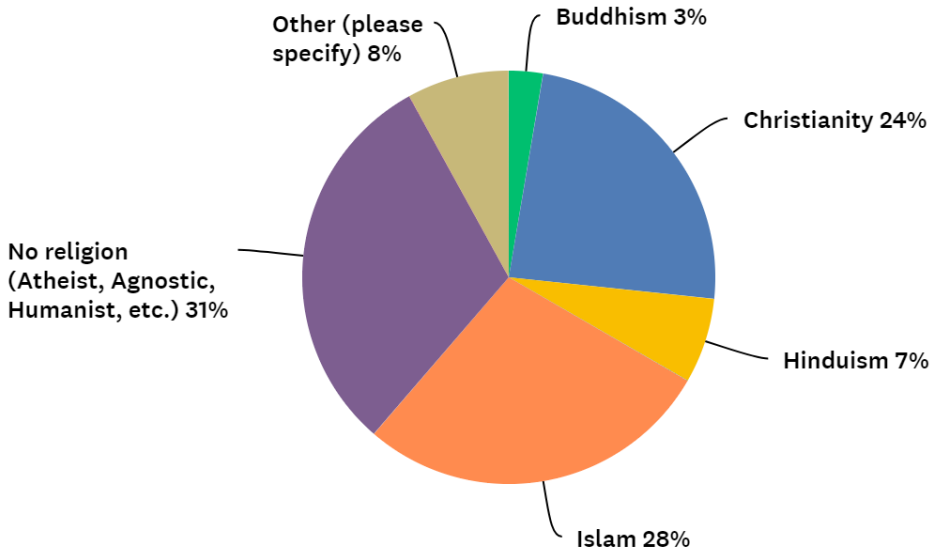




[27] 80 out 135 people answered the question on their age range.

Religion

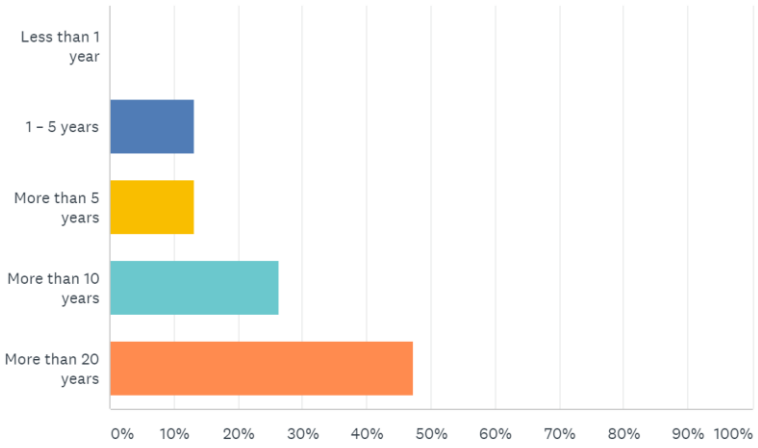
From the survey, most people who disclosed their religious affiliation did not identify with a religious group, 31 per cent (23) identified with 'no religion', the second largest was Islam at 28 per cent (21), followed by Christianity with 24 per cent (18). Hinduism and Buddhism also feature as well as self-defined classifications[28].



Whether participants were born in the UK

There were 53 per cent (39) of people not born in the UK, the majority of those, 47 per cent (18) had lived in the UK for more than 20 years, 26 per cent (10) lived in the UK for over ten years and those who lived more than five years and between one to five years were each at 13 per cent (5) each.

Length of time in the UK when born outside the UK

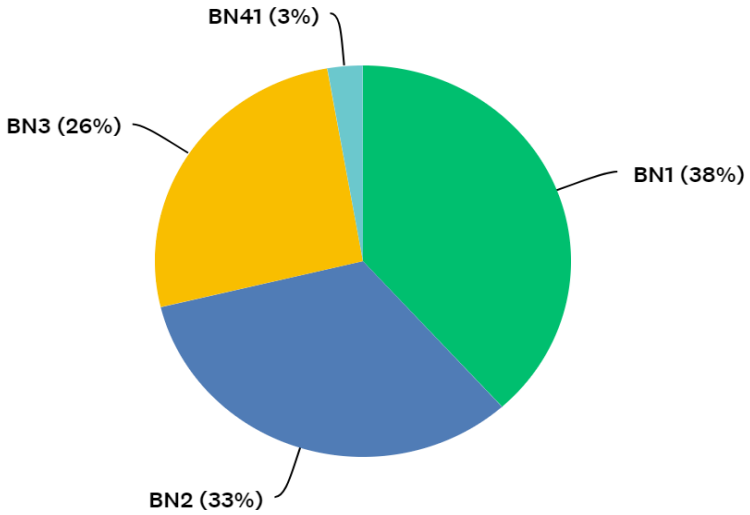


[28] Several people self-described as 'spirituality' and one as 'Jedi' and another as 'Magic'.,

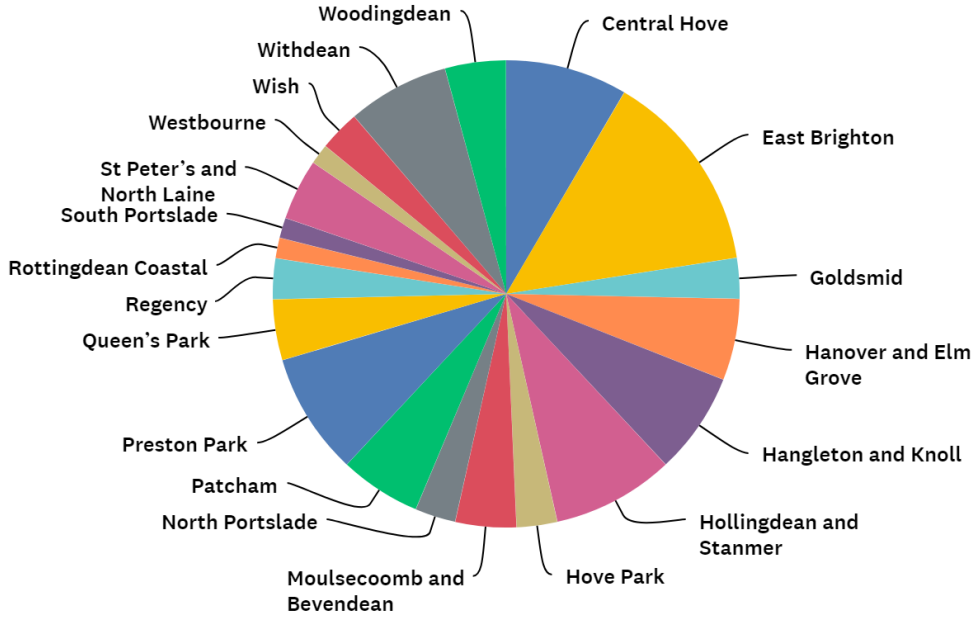
Location

There was a broad representation from across the city from survey respondents, there was small showing in BN41 (Portslade, parts of Hove and Southwick) with only 3 per cent. Breaking the location down into wards shows great level of participation across the city with respondents to the survey, all but 1 of the 21 wards (Brunswick and Adelaide) was represented in the survey responses.

Postcode distribution of survey participants[29]



Ward distribution of survey participants[30]



[29] 73 people answered this question.
[30] 71 people answered this question.

Results and key themes: Black, Asian and minoritised ethnic experience in the face COVID-19

Contracting COVID-19

There are some very notable barriers faced by many BAMER people, which have not been created by COVID-19 but the Public Health Report[31] has identified as , 'longstanding inequalities …. exacerbated by COVID-19'. The rationalisations as to disproportionate impact on BAMER people are varied to date but there are strong associations drawn from reports[32] and ONS data sources, suggesting that socio-economic disadvantage, incidence of co-morbid conditions, mental health, racism, stigma, fear and trust, key workers occupations, housing and financial vulnerabilities may all impact BAMER communities disproportionately.

This research shows that 13 per cent of all respondents (40) across surveys, interviews and focus groups said that either they or a household member had contracted COVID-19, a further six per cent said that they were not sure if they had had it. From this cohort, 32 people gave further information, 53 per cent (17) had contracted it themselves, 31 per cent (11) said a household member had contracted the virus and 19 per cent (6) said that more than two people in their household had caught COVID-19[33]. A South Asian woman describes how many of her family members caught COVID-19, which resulted in her mother-in-law's death, after contracting it whilst abroad. Her mother-in-law was tested for COVID-19 once she was admitted to hospital, where it was confirmed. She explains:

> *She [her mother-in-law] went in with breathing difficulty, high temperature, had underlying health conditions and it got to her lungs. She died within hours . . . she passed away, no time for treatment. We did not receive any treatment, it was really scary as it was at the beginning knowing whether it was COVID or just a flu but this flu lasted longer and the pains were and symptoms of the flu was severe not like other times. There was no test available at that time. My husband had just returned from [redacted] with his mum. His mum had flu like symptoms in [redacted] which got worse upon her return. He isolated in one bedroom and using his own bathroom whilst the rest of the family used a different bathroom with constant cleaning etc.*

Her mother-in-law had received a shielding letter, because of her underlying health conditions of diabetes, high blood pressure and heart issues.

[31] Public Health England (2020a) Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups, London. https://assets.publishing.service. gov.uk/government/uploads/system/uploads/ attachment_data/file/892376/COVID_stakeholder_ engagement_synthesis_beyond_the_data.pdf
[32] The Runnymede Trust (2020) 'Economic impact of coronavirus', London. www. runnymedetrust.org/uploads/ policyResponses/ EconomicImpactOfCovid19TreasuryCommittee SubmissionMay2020.pdf; RCN (Royal College of Nursing) (2020) 'BAME nursing staff experiencing greater PPE shortages despite COVID-19 risk warnings', 28 May. www. rcn.org.uk/news-and-events/news/uk-bamenursing-staff-experiencing-greater-ppe-shortagescovid-19-280520; Public Health England (2020) Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups, London. https://assets.publishing.service. gov.uk/government/uploads/system/uploads/ attachment_data/file/892376/COVID_stakeholder_ engagement_synthesis_beyond_the_data.pdf; The Runnymede Trust (2020) 'Over-exposed and under-protected: The devastating impact of COVID-19 on Black and minority ethnic communities in Great Britain', London. www.runnymedetrust.org/uploads/Runnymede%20Covid19%20Survey%20report%20v3.pdf
[33] Some respondents filled this in more than one category.

COVID-19 and uncertainty of prognosis

There was a lot of uncertainty around whether individuals and households had contracted COVID-19 as many were told that tests were unavailable. **Interviewee 118** is a Southern European woman who worked at the hospital and got mild symptoms of COVID-19 and was not given a test. She was asked if she had been tested:

> *Not at the time. My symptoms were mild, I lost taste and smell but at the time these symptoms had not been approved by the OMS so I was told I didn't need a test. Because I work in the hospital I had the antibodies test, later on and it was positive.*
>
> *We don't know if they [her household] have had it. They haven't been tested and did not have symptoms. It was the GP who suggested I stay at home. I asked for a test, and he said that if I was feeling well I didn't need it unless I would be admitted to hospital . . . No, no treatment was given, I was told to stay at home and go back to work in 7 days if I felt ok.*

Another respondent explained her inability to access tests, even though she had received an NHS shielding letter. She describes COVID-19 symptoms but is still left unclear as to whether she had contracted the virus.

> *Yes. I had symptoms [of COVID-19] of losing taste and difficult breathing . . . No. They [the tests] weren't available then, so I don't know if I definitely had it or not. I am on lots of tablets for my heart, blood pressure, diabetes and osteoarthritis. I have a memory problem as well – I'm planning to go and get an Alzheimer's test – the doctor recommended it but that's been put on hold due to lockdown.*
>
> *Yeah, got a letter from the NHS to say they should shield at home. They just stayed at home. And I didn't know for certain, because at that point there wasn't any testing.*

People who believed they had contracted COVID-19 were keen to follow the rules of confinement, self-isolating as best as they could and getting advice from 111.

> *Yes, I had it at the end of March. I had the symptoms but no test. I called 111 and they told me to stay home for 7 days . . . I live with my husband, but he is high risk, so I kept away from him in a different room the whole time I had symptoms . . . my husband has received 2 letters [shielding letters] . . . I called 111 when I had symptoms. They advised to take paracetamol. It was almost 10 days until I felt better.*
>
> **Interviewee 30, a woman in her 40s self-described as African**

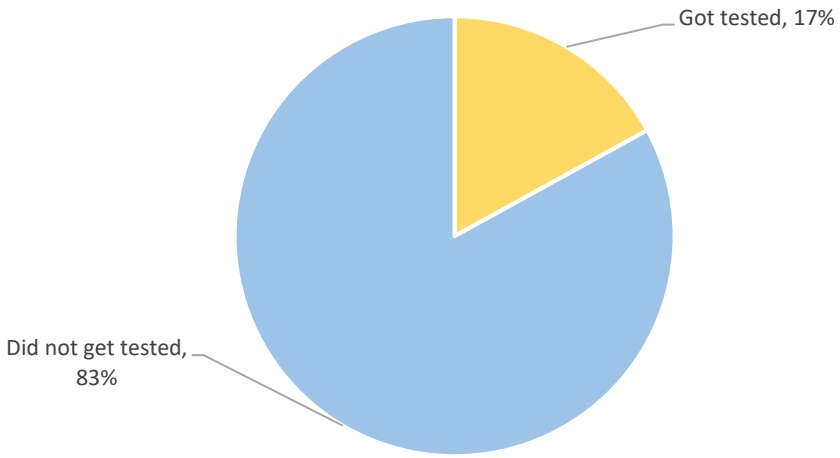
An NHS bank staff member recalls her nervousness of not only fearing she had contracted COVID-19 itself but her fear of losing her accommodation:

> *I may have had coronavirus, as I had some of the symptoms, but it was possibly flu. I had to stop work as this was as a member of the NHS 'bank' staff . . . a test*

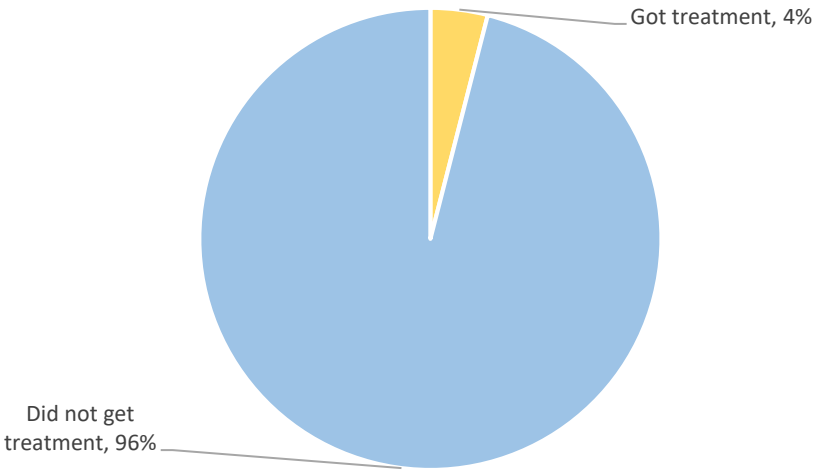
> *was not available. This was early in the period of lockdown . . . I shut myself in my room for 2 weeks and did not tell anyone at the house about my fears, as this risked losing the place in the house. I went round the house cleaning door handles etc. whenever it was quiet.*
>
> **Interviewee 132, woman**

She had an anti-body test before she returned to work, but her result came out negative.
Of the 23 people in the survey who answered the question of whether they were offered and given a test, 17 per cent (4 people) received a test and only 4 per cent (1 person) said that they received treatment.

Testing of BAMER individuals who said they contracted COVID-19



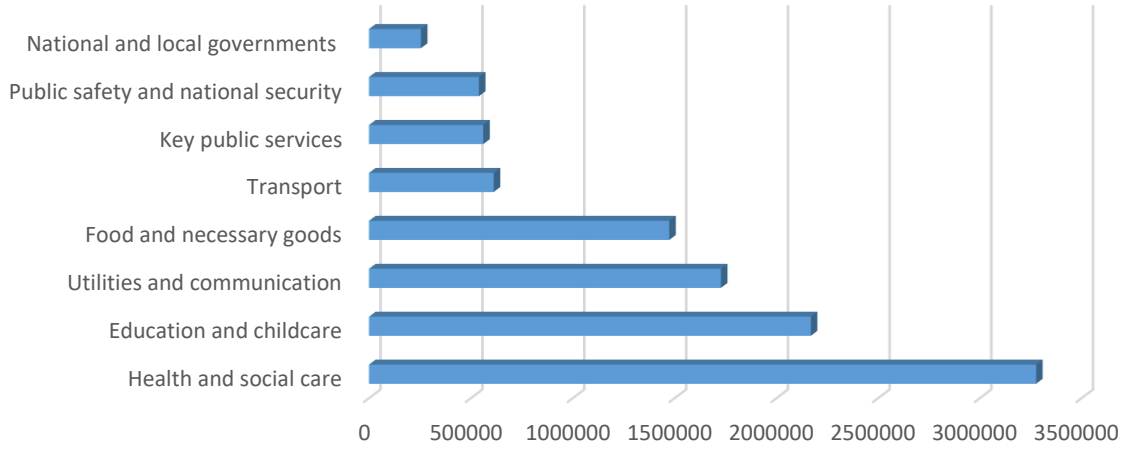
Getting treatment for BAMER individuals COVID-19



Working conditions and COVID-19

ONS sources state that nationally, 33 per cent of the total workforce were key workers, this is largely in line with Brighton and Hove, where 31.3 per cent of the workforce are key workers[34]. Nationally, approximately 40 per cent of NHS doctors[35], 20 per cent of nurses and 21 percent of adult social workers[36] come from BAMER backgrounds, which is disproportionately high when compared to the British white population. Given that BAMER people make up 14 per cent of the nation's population, it perhaps signals the risks of transmission which may increase occupational risk[37].

Number of key workers by occupation group in UK



ONS figures 2020

Interviews conducted in this study captured the concerns raised by frontline staff about going to work and the increased risk of exposure to COVID-19 among BAMER staff in many areas of work, but particularly in NHS and social care settings.

Working in the NHS and social care settings

Data from the *Intensive Care National Audit and Research Centre*[38] indicates that 34.5 per cent of critically ill COVID-19 patients are from BAMER backgrounds, given that BAMER people make up 14 per cent of the population, there is an obvious disparity. A letter from NHS England[39] urged NHS trusts and foundations to make 'appropriate arrangements' that could include removing BAMER nurses from frontline roles as it acknowledges that research shows that BAMER workers are being disproportionately affected by COVID-19. Additionally, BAMER workers are often in lower paid roles within the NHS, which means that these roles cannot be done remotely leading to greater exposure with other members of the community[40] or they are on zero-hour contracts or bank staff.

[34] https://www.ons.gov.uk
[35] https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff
[36] https://www.prospectmagazine.co.uk/politics/uk-bame-deaths-coronavirus-covid-19-why-nhs
[37] https://diversityuk.org/diversity-in-the-uk/#:~:text=In%202018%20about%2013.8%25%20of,Minority%20Ethnic%20(BAME)%20background.
[38] file:///C:/Users/sasid/Downloads/ICNARC%20COVID-19%20report.pdf.pdf
[39] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/second-phase-of-nhs-response-to-covid-19-letter-to-chief-execs-29-april-2020.pdf
[40] Public Health England (2020) Beyond the Data, ibid.

Inequality in the workplace

Structural barriers and systemic discrimination faced by BAMER staff have been documented widely elsewhere[41] and was evident in the research conducted in Brighton and Hove. A 2019 NHS Staff Survey revealed 15.3 per cent of ethnic minority staff reported experiencing discrimination at work from a manager, team leader or other colleague in the past 12 months; more than double the proportion of white staff.[42] This was compounded for those BAMER staff who were working as agency staff/on zero-hour contracts. They would often not be entitled to full sick leave if they contracted COVID-19 nor feel able to challenge working conditions that made them feel uncomfortable or afraid.

Interviewee 132, a BAMER woman whose experience perhaps captures the difficulty faced by key workers who are subject to unfavourable working conditions of zero hours contracts:

> *A zero hours contract with the NHS bank of health care assistants. Not paid when ill, so returned to work as soon as allowed, to pay the rent. The PPE at the hospital was not available at first (except for the usual apron, gloves and simple masks) but was better after a while, for example, a proper medical mask. There was no indication of any coronavirus risk assessment in the early weeks. For example, worked on the respiratory ward, then sent to other wards. Did not feel that this was safe and objected, but had to accept the shifts offered.*

When asked in the survey, if individuals, who worked as key workers, felt that they were expected to take a higher risk compared to white colleagues, 21 per cent (9) answered 'yes', whilst 42 per cent (18) did not feel they were treated differently at work and 35 per cent (15) said they were 'not sure'. This differential treatment is an area worthy of further exploration. It suggests that discriminatory practices were a concern that existed prior to COVID-19, but the consequences had now manifested in contracting a virus. One survey respondent expressed her frustration with her lack of control over her working conditions in a local hospital.

> *I was constantly moved to cover higher risk areas. My white colleague would request the move and my line manager would approve. I am expected to be the one who travels and enters spaces with others who have may have been in situations where social distancing was not observed*
>
> **A survey respondent that identified as a British Black woman**

There is a deep undercurrent and explicit wish to be treated fairly in the workplace and often an inability to express their concerns effectively and have these issues addressed in a meaningful manner.

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[41] Li, Y. and Heath, A. (2018) 'Persisting disadvantages: A study of labour market dynamics of ethnic unemployment and earnings in the UK (2009– 2015)', Journal of Ethnic Minority Studies 46(5): 857–878. www.tandfonline.com/doi/full/10.1080/136 9183X.2018.1539241; https://features.kingsfund.org.uk/2020/07/ethnic-minority-nhs-staff-racism-discrimination/index.html?_ga=2.83968145.900437054.1598098687-1079714911.1592215382 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf; https://www.kingsfund.org.uk/sites/default/files/2020-07/workforce-race-inequalities-inclusion-nhs-providers-july2020.pdf

[42] https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

This survey respondent expressed how contracting COVID-19 meant that not only would she become ill, but she would be without a wage due to her contractual terms:

> *As a Bank HCA, the nurses always send u [sic] to work closely with serious cases and it's hard because if u [sic] get sick don't get any payment.*
>
> **A survey respondent that identified as other white ethnic woman**

The following healthcare staff expressed their particular fears of working in high risk workplaces as BAMER members of staff. There was heightened fearfulness, powerlessness and vulnerability in the workplace. Two medical staff who filled in the survey expressed the following:

> *There was no recognition of the relationship of BAMER and COVID, even though it was in the media. I was refused a risk assessment and was still expected to go onto 'Red' wards.*
>
> **A survey respondent woman of South Asian heritage**

> *. . . assumed to work in clinic when feel anxious about coming in due to heightened BAMER risk.*
>
> **A survey respondent woman who identified as multiple heritage**

> *The Trust I used to work for contacted me about coming out of retirement, and part of me wanted to but that was before Black Lives Matter, and I thought they'd end up just putting me somewhere.*
>
> **Interviewee 161, no data given**

BAMER staff expressed fears of being put in additional harm to their white counterparts, because of their ethnicity. This was particularly acute for those who were working through an agency and/or on zero hours contracts who were often even less able to negotiate their working conditions.

Another layer of concern was the lack of PPE, **Interviewee 81**, expresses her frustration of not being tested, her concern was centred more about the lack of PPE rather than working as a key worker.

> *I tried to get a test when I had Coronavirus which was in April but I couldn't get a test, even though I work with the NHS through an agency. This was the NHS's fault as I should have had a test. I did the antibody test in June/July which was positive.*
>
> *Yes I did take more risks because of the lack of PPE. But I chose to work with COVID, it was my choice. Unnecessary risks were added because of the inadequate supply of PPE. When I got Coronavirus in April I managed the symptoms myself. I didn't call my GP or call 111. I told my employer and I didn't go to hospital. If I got it now I would call Track and Trace and then 111 if it got worse.*
>
> *I was an agency worker with the NHS on a Zero hours contract . . . I had to work outside the home as I am an essential worker . . . No I didn't feel safe as there was a lack of PPE . . . Give me a pay rise, more PPE, give us what we need to work properly*
>
> **Interviewee 81, a woman of Eastern European heritage**

The stress, fear and anxiety expressed by key workers whilst caring for or providing services around others is palpable. BAMER key workers are concerned about contracting COVID-19, infecting others, not having enough PPE, the impact of watching people in their care suffer, and not feeling safe in their working environment. This is in addition to the disproportionate impact of the virus on BAMER people.

> *I am a key worker. I do not feel safe at work. I believe I was expected to take higher risks than my white colleagues . . . A mask and gloves. To my knowledge, no risk assessment was carried out. . . . I think I should have been provided a visor too.*
>
> **Interviewee 106, a woman from a West African heritage**

> *. . . yes, I was in high risk because some elderly residents at my workplace had coronavirus. We worked under pressure every day actually.*
>
> **Interviewee 92, a woman of Chinese heritage**

> *It is a very scary time for everybody and when they don't give you information you get more scared. It would be better if I did not have to go to work and the NHS gave us more information on what we should do to really protect ourselves. Is there anything we should be doing or taking? I don't know, they are not telling us enough.*
>
> **Interviewee 141, a woman of West African heritage**

Discrimination was expressed particularly amongst BAMER health key workers and to a lesser extent by care home workers. Whilst discrimination was not expressed of all BAMER key workers within the NHS and social care settings, it was a significant experience that warrants highlighting and worthy of further investigation.

For some other BAMER staff in these settings, whilst fears existed, they did not express the sense of feeling treated differently because of their ethnicity. **Interviewee 133**, was a woman of East African heritage, who was a care worker and explained how she, "*. . . felt safe. It was risky, but no-one got the virus. Worried at first, but not after a while*". She was satisfied that she had the personal protection equipment (PPE) that she needed and that her employers had treated her respectfully. **Interviewee 102**, a key worker, whilst not feeling discriminated against still expressed not feeling safe in the workplace but did not feel singled out because of her ethnic origins.

> *I did not feel safe at work. I suffer from asthma . . . not all my colleagues wore a mask. My colleagues and I are all from different ethnicities and were treated equally . . . My employer provided us with a mask, but not every day, as they run out. I bought my own mask. As far as I am aware no risk assessment was carried out.*
>
> **Interviewee 102, a woman of West African heritage**

Key workers in other sectors

Outside the health and care sector, many BAMER people held essential jobs in sectors such as retail, public transport, delivery services, putting them on the frontline and at risk of exposure to COVID-19. **Interviewee 109's** husband worked as a delivery driver and had no option but to carry on working outside the home.

> *My husband took risks as he carried on working for [redacted] during the lockdown, however he accepted this as he needed to work*
>
> **Interviewee 109, a woman of South American heritage**

Likewise, **Interviewee 108's** husband also worked as a delivery driver for another well-known company.

> *My husband was employed by [redacted] on a zero hours contract. My husband worked all through lockdown for [redacted]. My husband uses his motorbike both before and during lockdown. He doesn't feel safe at work as he has contact with people he doesn't know. Often the customer didn't follow social distancing guidelines and was waiting at the door with door open, which was unsafe.*
>
> **Interviewee 108, a woman of South Asian heritage**

There were other essential workers that did feel supported by their employers. **Interviewee 110** was employed full time with contract in a shop.

> *Yes I carried on working outside the home all the time in lockdown, with same number of hours. I was an essential worker. Yes I feel safe at work . . . I was not expected to take higher risks than my colleagues. My employer provided me with hand sanitiser and mask . . . my employer carried out a Coronavirus risk assessment. We are a shop and there are restrictions on number of customers entering the shop at one time and social distancing is enforced . . . I did [got] the PPE I needed.*
>
> **Interviewee 110, a man of South American heritage**

> *Working in catering industry as a chef so business was open for takeaways . . . Yes had to work outside of work and stayed at place of work with colleagues in one room, came home once a week on day off. no not essential worker as in catering sector . . . No PPE provided, still feel safe as had no contact with anyone with virus. No risk assessment done. No . . . [PPE received] . . . just handwashing and cleaning.*
>
> **Interviewee 46, a man of South Asian heritage**

> *I am at greater risk from the virus due to my ethnicity and this was not taken into account until my organisation was forced to do a risk assessment. I was telling them I was at greater risk but they didn't listen to me and were forcing me to come into base which comprised a busy hotdesking office*
>
> **Survey respondent**

This increased risk of exposure to COVID-19 by key workers, who were most likely to have social contact, were most prone to being infected themselves. Key workers often spoke about the importance of PPE (personal protective equipment) and risk assessments.

Personal protection equipment (PPE) and risk assessments in the workplace

Respondents in this study, who had to work through the lockdown period of the COVID-19 epidemic, expressed the importance of: being provided with adequate in-date PPE , risk assessments in the

workplace and a duty of care from their employers to them as key workers. They also mentioned their particular vulnerability as BAMER staff when faced with occupational risk.

> *No I didn't feel safe as there was a lack of PPE . . . The NHS provided PPE within Public Health guidelines, but I didn't feel it was appropriate because it was not in line with WHO guidelines. The Public Health changed the guidelines, which I didn't agree with. We had masks with an expired 'Use by' date which were 'relabelled' with different dates many times and the Government said it was ok to use these masks, but I didn't feel safe with the guidance.*
>
> *The NHS didn't do a risk assessment for me personally, but probably did for permanent staff. I was on a zero hours agency contract and offered myself to work during the lockdown. I didn't have any underlying conditions so I didn't need a risk assessment.*
>
> *When asked if she had received enough PPE (personal protection equipment) you needed?*
>
> *In my opinion No we didn't. I think we should have had more PPE that was not out of date. The PPE was not thorough. We were meant to have full gowns when dealing with positive Coronavirus patients but we only had aprons, which were not safe.*
>
> **Interviewee 81, a woman of Eastern European heritage**

> *Yes, I work in a school as a [redacted]. The school was closed for a time, but then it reopened . . . As I was worried about my condition, I asked to wear gloves and a mask, but I was told I wasn't allowed as it would scare the children. Also even though the children were asked to keep socially distant, they are very little, and they didn't. I was worried because most of the children at that time were children of key workers, so I had concerns. [Did you get the PPE you needed?] No, even though I specifically asked for it.*
>
> **Interviewee 36, a woman of South Asian heritage**

Interviewee 25 worked in customer services, she felt safe and did not feel they were faced with any further risk. Their employee offered 'gloves and cleaning' and this level of PPE was satisfactory to her. The BAMER key workers as described by **Interviewee 17**, explained how even with PPE, she did not feel comfortable in her workplace as she was asked to 'cover for' absent staff and as result she was having to take additional risk.

> *At first was reluctant to go but was my decision to go I was allowed to opt out should I wished to do so. Only few hours a week. Felt like the vulnerable needed the help most during this pandemic. Did not feel safe at beginning as it first happened and no PPE then we were offered PPE. Yes I think we were taking higher level of risk being from BAMER background and having close contact with client. I was often called to cover as some colleagues decided to not to work so felt like being asked a lot taking higher level of risk and bringing it back to my home. Back of mind knew taking risks even with PPE.*
>
> **Interviewee 17, identified as a British Black woman**

Likewise, **Interviewee 108** spoke about her husband's workplace and how ' [redacted] *didn't provide PPE. He had his own Balaclava and hand sanitizer.* [redacted] *didn't do any risk assessment . . . My husband took it [PPE] himself*'.

Key workers across the sectors expressed the importance of adequate PPE provision, robust systems, wellbeing and risk assessments, occupational risk assessments and their concerns about risk being heard and addressed. Not having these concerns addressed left workers feeling undervalued and vulnerable to the virus. Implementation of demonstrable support of BAMER staff in the face of a pandemic, where staff felt heard, protected and supported could help make BAMER staff feel assured that disparity was being addressed.

Information, communication and messaging

Understanding of COVID-19

Amongst the interviewees and focus group participants there was a high level of awareness of COVID-19 symptoms with only five per cent (9) of interviewees expressing uncertainty of symptoms. This group was sometimes able to name a symptom or two but also expressing confusion. There were two groups of people that expressed uncertainty, the first were people who had lived in the UK for less than five years such as **Interviewee 126** who was a woman of North West African heritage who had lived in the UK for less than five years, whilst recalling two of the symptoms correctly still expressed confusion.

> *The question is really hard – there has been lots of information and is has become quite confused. Some stomach pains, cough, fever*.

Interviewee 83 a man of mixed heritage who had also lived in the UK for less than five years. When asked about COVID-19 symptoms, he also expressed uncertainty, saying, *'I'm not sure, I know it's dangerous'*.

The other group were older people who often relied on family members to share information about COVID-19. **Interviewee 72**, a woman of East Asian heritage, who had lived in the UK for over 20 years said, '*I do not remember but my husband does and he has had told me before*'. The misunderstanding around COVID-19 however, still elicited an appropriate response on what they would do if they were unwell, they would phone the GP, call 111 or contact a family member or friend to support them to contact medical advice or assistance. Misunderstanding of COVID-19 symptoms did not appear to be centred around a single ethnic group.

In contrast, 95 per cent of people interviewed appeared to have a very good grasp of what COVID-19 symptoms were. Typical answers mentioned a new continuous cough and a high temperature, fewer people mentioned loss or change of taste.

> Fever, temperature and cough
>
> **Interviewee 122, a woman of Nigerian heritage**

> *Cough, chest, breathing difficulty high temp, loss of smell and taste.*
>
> **Interviewee 50, a woman of Jordanian heritage**

There were sometimes the inclusion of additional symptoms such as 'breathing difficulty', 'sore throat', 'headache', 'fatigue' and 'diarrhoea' which whilst not on the NHS website was acknowledged from respected studies, such as the *COVID Symptom Study* led by King's College London.[43] Interviewees were almost united in their understanding in what to do if they contracted COVID-19, even those who were unsure about the symptoms were aware of isolating, calling 111 or calling their GP. For a few others it would be calling a trusted friend and/or family to ask for advice or support to contact 111 or the GP. There was a recognition amongst interviewees about the importance of social distancing, isolating at home and before official guidance, wearing of face coverings. BAMER people appeared to exercise extra precautions and tried to find strategies to mitigate risk. This reality of BAMER people in Brighton and Hove challenges some of the baseless assertions made by a UK

[43] https://www.medrxiv.org/content/10.1101/2020.06.12.20129056v1

Member of Parliament[44], and councillors[45] who sought to blame BAMER groups for the spread of COVID-19. BAMER people interviewed for this research expressed a nervousness about taking additional risks such as going shopping, public transport and going to work.

> No – we didn't go out initially for about a month and a half. We did the shopping in one go. We eat chapattis, lentils and tinned food so we didn't have to go out to get more food. Even now when I go out, I wear a mask and I only talk to people I know and I keep a distance. Even now, the shops are only allowed so many people. We also didn't go out just in case we had it and passed it on.
>
> **Interviewee 151, a woman of Indian heritage**

There were several concerns expressed about the lack of mask wearing in the UK amongst the general public prior to the 24th of July 2020.

> One thing I was concerned about was the mask wearing. In my country, mask wearing is common so I don't understand why they are not worn here. Also, people look at me when I do wear one, like I have the coronavirus.
>
> **Interview 125, a woman of South East Asian heritage**

Source of information

From the interviews and focus groups 152 (out of 175 people) and 85 (out of 135 people) survey respondents spoke of how they received their information about COVID-19. These 237 people spoke about the multiple sources that they used to learn more about the virus. It was rare for people to be using a single source of information. Of the 237 who responded to the '*where they got their information about COVID-19*' question, the most popular sources were:

- 79 per cent television;
- 55 per cent through social media and/or Facebook;.
- 52 per cent from friends and family and
- 49 percent from Government briefings

Other sources included:

- 30 per cent newspapers (including online newspapers);
- 21 per cent used local community, voluntary and religious groups as a source;
- 19 per cent news channels outside of the UK;
- 15 percent the NHS;
- 11 per cent radio and
- 11 per cent emails (from various sources including colleges, workplaces, community groups)
- only six percent mentioned word of mouth.

Survey respondents also included alternative sources of information including 'up-to-date research'. 'GP and BHCC' sources, through work and through 'employer briefings'.

[44] http://www.standuptoracism.org.uk/anti-racists-hit-back-at-tories-and-say-no-covid-racist-scapegoating/
[45] https://www.theguardian.com/world/2020/jun/10/tory-councillors-accused-of-racist-posts-on-social-media

Across both survey respondents and interviewees, there was a searching, researching, investigating and scrutinising of information as individuals sought reliable sources that contained 'accurate' data or guidance, local data, trusted information and comparisons with how other countries were dealing with the pandemic. This informed people's measure of how the UK was doing.

> *Before I felt angry because I saw how other countries were doing lockdown and I was angry that nothing was happening here, it was not strict and people were acting as if everything was normal. Now I think we should keep it for longer because otherwise the lockdown we did do and the changes we made would have been for nothing.*
>
> **Interviewee 126, Female Moroccan**

> *I used to watch Moroccan TV channels to get information about coronavirus, including advice about sanitation, washing hands, keeping my family safe etc. I can watch English TV channels and although I don't understand I sometimes get the idea. I find Moroccan TV channels better because they give you more information about the virus.*
>
> **Interviewee 128, Moroccan woman**

> *From the NHS website and also I'm on the Join ZOE app, from King's College. I'm trying not to watch the news. I don't believe the news or the government. I also access the office for national statistics. Basically, not Boris Johnson.*
>
> **Interviewee 33, a woman of Indian heritage**

Interviewees and survey respondents expressed distrust in the Government. Of the 84 people who described their feelings since the lockdown, 50 per cent expressed distrust of the UK government and/or media. Those medical professionals who shared a platform with Government officials were seen as less trustworthy.

> *I've been watching and reading everything coming through and reading between the lines/unpicking it. But I've been getting angry at the TV for not giving enough information about symptoms, and for the lies saying that people on the frontline were being tested. I stopped asking my frontline worker family members and friends about it, because it just wasn't true. They were mixed messaging right from day 1 for everybody, not just BAME or purple people or whatever, and breaking rules came from top government for example Cummins, so I was feeling really sad.*
>
> **Interviewee 161, No information recorded**

The NHS, in contrast, was seen as a trusted source of information. There were a lot of requests for receiving more clarity and guidance from the NHS.

Clear and simple information

Respondents saw the NHS as a trusted organisation that is best placed to give out information around COVID-19. People in this study asked the NHS for guidance, information and media in plain English, that is culturally appropriate and for those who require it in different languages. There were requests

for information that would alleviate people fears and balance misinformation found elsewhere. There were hopes for preventative advice and culturally competent information around health prevention and disease prevention programmes as explored by the recent Public Health England report, *Beyond the Data*[46]

> *I felt that there was very little shared directly by the NHS, or perhaps it was but it didn't reach me as such. Like most people, I would have preferred clearer guidance, perhaps via a dedicated website or through email.*
>
> **Interviewee 88, woman unknown heritage**

> *Of course it would be much better if we got letters from the NHS. The information would be clearer and more accurate. Leaflets or letters would definitely have helped us as we were confused with lots of different resources.*
>
> **Interviewee 142, woman of Arab heritage**

> *Well maybe some simple language information that told you what to look out for, maybe there was already a lot of it about. But I don't remember seeing much of it. I never saw any leaflets from the surgery or anything. Maybe that would have helped some. Them I would not have to rely on my children as much.*
>
> **Interviewee 143, woman of Nigerian heritage**

> *Clear information, in Bengali, leaflet that I can look at as quick guidance at hand. Being in lockdown for four months regular updates. texts, email , letter.*
>
> **Interviewee 42, woman of Bangladeshi heritage**

> *Someone to help me with my medical problem. I don't feel like my GP is helping me. The information about shielding was not clear or consistent regarding diabetes, so I was confused. The NHS website and other information was contradictory.*
>
> **Interviewee 36, woman of Bangladeshi heritage**

A lack of clarity meant that people had genuine misunderstandings, confusion or concerns about not being able to access the most appropriate care, treatment or source of advice.

> *Self-isolate in house and tell house mates. Take test, however I don't know how to ask for test – I should have been told how to book a test. I wouldn't go to GP or hospital.*
>
> **Interviewee 108, woman of White Brazilian heritage**

> *I would call 109* [the interviewer clarified several times that interviewee didn't mean 111 or 999]. *When we thought my husband had corona virus*

46 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

> *symptoms we called the GP and they said call a special helpline on 109.*
> **Interviewee 47, woman mixed heritage**

There were also requests to consider giving advice and reassurance around specific religious celebrations such as Eid, which occurred after the strict lockdown rules were relaxed but when the logistics were not clear. The opening up of restaurants, pubs and some workplaces have also made the rules less clear. There was not a request to evade the rules but have clarity.

> *Clear information, leaflets in plain language and where can access directly the information required. It would be good to receive information based on my religious beliefs as we have had Eid during first ease of lockdown and it was scary and confusing as to what is allowed or not. It was extremely difficult and emotional for us. So a direct message during Eid from government or the NHS would have been ideal directly telling us of what is and what isn't allowed. We had spent Ramadan in lockdown with no mosque it was very difficult and emotional and not good for mental health so mental health support and getting support from religious groups would have been ideal during this tough time. Guidance from NHS and government supporting religious cultural groups to support the community*
> **Interviewee 149, male of Bangladeshi heritage**

The importance of the NHS to provide clear, comprehensive and myth busting advice was critical, particularly when the Government was seen a divisive or untrustworthy. A lack of good quality, trusted information meant that people would search for information elsewhere instead.

> *We got out information from the TV news from our family some on Facebook and some from home Ghana. We had a lot of places to get the news. It was so scary we wanted to make sure we had all the information we needed. You can't trust the Government to tell you everything you need to know. You don't know what they telling you and if it's the truth. I don't believe them sometime the Government.*
> **Interviewee 141, woman of Ghanaian heritage**

The accurate information void was filled from any number of sources, some of which were well researched, from trustworthy websites, organisations and research bodies; whilst for others this left room for conspiracies, false rumours and fake news stories.

Fake news and conspiracy theories

As there were lots of uncertainty with limited if any prior knowledge of Covid-19 prior to lockdown, some people did their own research instead. For some this meant going to reliable sources, of which there are many, however for others in a heightened state of stress[47] and in search for resolution, they were not always so discerning about reliable sources of information[48].

> *Clearer and trusted information would have helped as there was lack of clarity. We were confused of the contradictions in the news and in social*

[47] https://www.sciencenews.org/article/coronavirus-covid19-stress-brain
[48] https://www.sciencenews.org/article/coronavirus-covid-19-how-fear-anger-change-risk-perception

> *media. To be honest, I am still suspicious about all COVID issue and it's relation to 5G networks and China. Translated letters and leaflets would have helped.*
>
> **Interviewee 63, man of Syrian heritage**

> *We were confused with lots of fake news. Some news were scary when you see people dying everywhere. It was a struggle to understand what's happening clearly. A clear translated letters from the NHS about virus and the ways it is transmitted would have helped.*
>
> **Interviewee 65, woman of Sudanese heritage**

> *At the beginning I was looking at social media like Facebook but I stopped because it was very upsetting and scary to see the death toll increasing every day. There were also a lot of fake and unreliable news. Later, I got my information from my family members who follow the government briefing.*
>
> **Interviewee 64, woman of Syrian heritage**

There were a lot of conspiracy theories which tended to be based on coincidences, misconstrued science, often with emotive language which at a time of public mistrust was readily consumed. Therefore, it is crucial for the NHS, as a trusted organisation to produce and make easily available and accessible a counter-narrative to conspiracies and misinformation.

Addressing barriers to accessing NHS care

Experiences in the NHS were varied. For many it was the epitome of how a health service can be run, a beacon of how healthcare benefits them when they most need it. For others, this was not how they experienced the NHS. How a BAMER person experienced the NHS could be determined by multiple factors, it could include the colour of a person's skin, their accent, their ability to speak English, their clothes, their religion and/or their difference, perceived or real. Whilst capturing these issues through people's experiences, what must not be lost in the narrative is the staff they encounter, the same BAMER person could experience excellent care in one doctor's surgery or NHS service and then experience racism or bad treatment in another. It was not unusual for interviewees to express positive responses towards the NHS and then later in the same interview relay a negative experience, sometimes racist, sometimes systemic, sometimes organisational, sometimes based on resources and capacity. This creates for some a complicated relationship with the NHS.

Positive experiences in the NHS

Appreciation and praise for the NHS was undeniable, 70 per cent of BAMER interviewees and focus groups (122) respondents expressed an overwhelming positive response. A range of typical positive responses are shown below, beginning with **Interviewee 9**, who despite the long wait for her husband's treatment, expressed her gratitude she and her husband received.

> *Excellent, I love the NHS. My husband was unwell and we had to go to A and E. Yes we had to wait for 9 hours, but they were very busy dealing with emergencies. We were both very scared, but were really taken care of. They were asking about him, but also taking care of me. I am so happy and proud of the NHS.*
>
> **Interviewee 9, woman of Syrian heritage**

> *Whenever I need them, I can access them and they are supportive. My daughter works in cancer research for the NHS, so I really appreciate them.*
>
> **Interviewee 30, woman who self-described as of African heritage**

> *Good, friendly staff*
>
> **Interviewee 20, man of Bangladeshi heritage**

> *Absolutely brilliant. We are really lucky to have the NHS and they have always been very respectful when we have used them. It's a great free medical service and I can't fault it. I have used GP services and the hospital for the birth of both my children. I also had a broken wrist and had to go to hospital for treatment.*
>
> **Interviewee 5, a woman who self-described as of British Asian heritage**

> *Two weeks ago my youngest, the baby who is nearly 3 had fallen. We thought she had a broken hand. We took her to the hospital and we were seen very quickly. My husband couldn't come in with me, as they were being very strict with the rules because of Coronavirus. I was treated very well and received good care. No problems. Other than that we haven't used any services.*

Interviewee 4, BAMER woman, no other recorded information

I've used number of services including: GP, pharmacists, dentist, occupation therapist, physiotherapist, direct payment, hospital, pain management clinic. My [redacted] years old daughter is in wheelchair . . . services here have so much higher standard that in my country of origin. I'm extremely grateful for all the support they give to me and my daughter. Sometimes you have to wait for the appointment for long time especially, for specialist services. Staff being usually very kind and supportive.

Interviewee 101, BAMER woman, no other recorded information

I have always loved the NHS. It provides an amazing service. I have never received treatment or services below my expectations, and I've never been treated like 2nd class, or received a service that was 2nd class.

Interviewee 3, woman of Bangladeshi heritage

Very good care, I get interpreter when I go without someone who can help me translate or they try to find a nurse or someone who speaks my language.

Interviewee 117, woman of mixed heritage

Negative experiences in the NHS

Conversely, other BAMER people either had a negative or a mixed set of experiences. Of the 175 interviewees and focus group respondents 49 per cent (86) expressed a negative experience. This ranged from communications and language barriers to negative impacts on their health when appointments were cancelled due to being treated in a way that was perceived as discriminatory.

Experiencing discrimination

Some BAMER people spoke of experiencing racial discrimination by health professionals. The impact of racial prejudice on a person's life chances can impact their mental and physical health. This can also impact the level of trust that BAMER groups have of NHS services and health care treatment they receive and reluctance to seek care on a timely basis, and reduce late presentation with an illness, condition or disease[49].

I talked to a professional, two years ago, with someone from the hospital and instead of helping, the person I was talking to started talking to someone else and started to make fun of me. After that incident I felt I would never call an NHS service again.

Interviewee 16, man of Arab heritage

I had an appointment with the gynaecologist which has been cancelled many times. During lockdown the face-to-face appointment was changed to telephone appointment but there was no interpreter so they hang up and have not contacted me again.

Interviewee 108, woman who self-described as a white South American heritage

[49] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

Sometimes not taken seriously or feel neglected treatment or care compared with others, feel discriminated. One point was hospitalised as did not diagnose earlier as white friend had same illness and was treated

Interviewee 18, man of South Asian heritage

Keeping family safe, recognising cultural background and not judging and treating differently, as sometimes feel spoken to differently as if I don't understand, but my English is very good and I have a good business and connect with people all the time. I just accept it thinking we are a foreigner but I should not have to.

Interviewee 146, a woman of Indian heritage

Do their job with equality in mind, and provide wellbeing services like mental health support specific to minorities, on their "ask" and not by white lead organisations.

Survey respondent

The first time I came to the UK, my husband took me to register for the NHS, the first time they denied me and my daughter, they said that we couldn't register because we didn't have proof of address, but I had an address on a bank statement so my husband [who is British] had to complain for me. The admin appeared bad and this resulted in denying me and my daughter to register at the local doctors' surgery.

Interviewee 125, woman of South East Asian heritage

At the clinic I did feel that I was not treated fairly. I sensed some bias against women and my race.

Interviewee 131, woman of Arab heritage

My son has been rushed into hospital yesterday after a week's wait and several phone calls to 111 and doctor they advised to stay at home and gave medication. He was not getting any better and finally the doctor made home visit after my sister-in-law [who speaks 'good English'] spoke with doctor and put pressure on. This shows we are not taken seriously and judged. It was appendix which was really bad as soon as he went to hospital he was operated on and got an infection due to being at home with it for too long. Which is really upsetting and frustrating and scary as it could have burst. It is very dangerous.

Interviewee 159, woman of Bangladeshi heritage

. . . compared to my country, when I am sick you can get medicine when you want and advice about how to get rid of the flu . . . One [white] British doctor I saw was quite strictly and said just to take ibuprofen and no other advice. Then I found that I should not ibuprofen because it's bad for your blood, and I have a problem with my blood and have to monitor it regularly . . . I met an Indian doctor after this and she gave me more advice and advised me to go to the hospital, and now whenever I have choice, I choose a doctor of Asian heritage, rather than a [white] British doctor.

Interviewee 125, woman of South East Asian heritage

Communication and language barriers

Not being understood, whether it is due to language barriers, disability or mental health, had a great impact on how NHS services were experienced. Individuals had reported being ignored, having the phone put down on them and being laughed at for having accents (as described above) or not being able to respond in English. There were also reports of feeling misunderstood due to mental health. **Interviewee 74**, a woman of Chinese heritage, spoke of her positive experience with health care, despite being unable to communicate in English, she highlights the value of being understood, "*they* [health care service] *were very good. Due to the language barrier, interpreter always had been booked for each visit which made me feel respected*".

> *Please open the surgeries doors and tell GPs to give us access to primary care. My surgery has locked their doors and does not answer the telephone. When I get through and arrange for a telephone consultation, they do not call me back.* **Interviewee 106, identified as Black Portuguese speaker**

> My scan appointment for monitoring my cancer was cancelled. My appointment to scan my eyes as part of my diabetic review was also cancelled… There was a huge negative impact on my health. When my chemotherapy finished on December last year, I have been told the cancer has mostly cured and the chance of it coming back in 2 years is very small. My review scan was cancelled and I had to self-isolate. After lockdown, I had to go to hospital due to severe pain to discover that my cancer is spreading fast. **Interpreting support provided to interviewee**

> *Language support when I needed to book an appointment to the GP and the GP should have been booked interpreter for all appointments not just when the meeting was obviously unsuccessful due the lack of understanding. I had very bad memories about inconvenient conversations due the missing interpreter. I always asked interpreter, but the GP thought I don't need them. He was wrong and it was terrible for me. I was in pain and dealt with multiply issues.* **Interviewee 58, woman of Hungarian heritage**

> Generally not great. Mental health causes problem with communication. Don't like the service, threaten to put phone down because I was getting distressed as they would not understand me. I need Medication, relying on them so stressed as they put phone down. They are Slow they don't understand me no empathy very stressful
> **Interviewee 21, male who self-described as of other Asian heritage**

> *Not as good as it should have been. I have been chasing information and appointments and it has been confusing. There have been difficulties with language, and I feel no one was taking the symptoms seriously. I have not been treated badly, but I don't feel that I have been given the appropriate attention and time . . . a really important appointment was cancelled. I have been waiting for this appointment for such a long time and have really had to push for it. I have had to ask a friend who translates . . . The appointment was really important and it was cancelled. There was no communication and the condition was really bad and painful. I was on very strong painkillers and it is still going on.* **Interviewee 36, woman of South Asian heritage**

Charges to Overseas Visitors

Although new regulations came into force on the 29th of January 2020, which added COVID-19 to the Schedule 1 of the NHS (charges to overseas visitors) Regulations[50], which meant that there was no charge made to an overseas visitor for the diagnosis, or, if positive, treatment, of the coronavirus. Further, there would be no charge applied to a diagnostic test even if the result is negative. Also there would be no charge applied to any treatment provided for suspected COVID-19 up to the point that it is negatively diagnosed. However, for those non-EEA nationals who do not have settled status in the UK, the fear of being charged was the overriding understanding during this pandemic and as suggested below by **Interviewee 46**.

> *Some kind of support for those who are on case to remain in UK waiting for results on case meanwhile having no access to NHS. What if I got ill or had an accident? Some kind of support from NHS for people like us as its scary if something to happen and not having access to healthcare.*
>
> **Interviewee 46, male Bangladeshi heritage**

COVID-19 lockdown impact on NHS services

Under the COVID-19 pandemic, there was severe disruption to regular NHS services, patients undergoing care for ongoing and new conditions and illnesses, some BAMER people faced deteriorating health and/or increased pain. Individuals were experiencing difficulties contacting services, leaving some people feeling distressed and/or frustrated.

> *My scan appointment for monitoring my cancer was cancelled . . . there was a huge negative impact on my health. When my chemotherapy finished on December last year, I have been told the cancer has mostly cured and the chance of it coming back in two years is very small. My review scan was cancelled and I had to self-isolate. After lockdown, I had to go to hospital due to severe pain to discover that my cancer is spreading fast . . . I believe that the scan and treatment for cancer patients should not have stopped because that would have a serious negative impact on their health and the outcome of the treatment.*
>
> **Interviewee 64, woman of West Asian heritage**

> *The cardiology department cancelled an appointment during lockdown . . . My heart condition has not been diagnosed yet, and I went to A and E three times. I am concerned with my health.*
>
> **Interviewee 102, woman of West African heritage**

> *My daughter has a health condition, she didn't get any letter from the GP. The hospital was supposed to contact us to make an appointment, but nothing happened, they never called us for blood tests and scan of her kidney. If we don't call them, they will not call us, but I guess because of COVID-19 they are not calling us, she is still taking antibiotics every day and we are waiting to see if they will tell us to stop because it has been a long time.*
>
> **Interviewee 122, woman of West Asian heritage**

[50] https://www.gov.uk/government/collections/nhs-visitor-and-migrant-cost-recovery-programme

I was pregnant for 3 months of the lockdown, so I didn't go out anywhere. I was using NHS maternity services, and was under an obstetrician care, which was generally positive, but because of coronavirus a lot things have changed. I had some appointments cancelled, and my husband wasn't allowed to attend any of our scans or appointments for last 3 months of my pregnancy, which we were both upset about . . . We were really looking forward to experiencing every part of the pregnancy together, so we feel like we've missed out in a way. I understand why they're doing it, for safety and social distancing. But it took some of the specialness away for us.

Interviewee 153, woman of South Asian heritage

Yes without medication I am suffering. Require injections for arthritis but this was to be changed to a different dose or type of injection before lockdown as the previous ones was not working. They have stopped giving me previous ones to give the new ones. Which I only just received the new one after waiting four months. This has had impacted me and limited my day-to-day activities.

Interviewee 18, man of South Asian heritage

. . . all my appointments were cancelled because of the coronavirus, my physiotherapy appointments were cancelled. The psychologist appointment that I finally got was then also cancelled. I had a phone appointment with the specialist and they said I need a special scan to see the disc but nothing has happened since then. So nothing can move forward with a solution. I have had some depression due to the chronic pain from my back during the lock down time. I asked for an appointment with a psychologist to discussed this and I asked three to four times at my GPs before I finally got an appointment with a psychologist and then it was cancelled because of coronavirus . . . Not having a resolution has been a serious problem because also in lockdown . . . everything falls to me and I struggle because of this pain.

Interviewee 122, woman of Syrian heritage

COVID-19 and the lockdown experience

Mental health

At the time of writing this report, findings from an ongoing COVID-19 social study by University College London (UCL)[51], is showing that BAMER people have had higher levels of depression and anxiety during the pandemic. This study is believed to be the UK's largest study into how adults are feeling about the lockdown and overall wellbeing and mental health. More than 70,000 participants have been involved in the research project and identifies that:

> *. . . people from BAME backgrounds have had higher levels of depression and anxiety during the coronavirus lockdown, as well as lower levels of happiness and life satisfaction. Overall, 35% of adult participants reported their mental health had been worse than usual, increasing to around half when looking at people from BAME backgrounds, young adults and people with a diagnosed mental illness.*[52]

The UCL findings are certainly reflected in this research, anxieties around employment, financial situation, working conditions (as discussed earlier), children's education, access to health services, mental health and wellbeing, catching COVID-19 (and the consequences), absence of Statutory Sick Pay where they are an agency or on a zero hours contract.

> *Very anxious at the beginning, I had bad nightmares often, and I was very worried about going to work. News created a lot of anxiety. They spoke about deaths in numbers constantly and I was scared of dying . . . The pandemic was very bad but I did what I had to do, kept going to work, didn't isolate, tried to carry on. I don't know what else could have helped . . . During the main lockdown the feeling of stress was bad and not good for everyone.*
>
> **Interviewee 126, woman of Moroccan heritage**

> *I am very worried, and anxious, I have been very scared, with no way out. I take pills to sleep. So many people dying at the beginning. I am already depressed and take medication for it, and the pandemic made my mental health much worse. Things are a bit better now.*
>
> **Interviewee 117, woman of mixed heritage**

> *No, my life hasn't changed much as because of my depression and anxiety I like to spend my time mostly in my flat . . . At the beginning my grandchildren also called off all visits . . . I have 2 cats to keep me a company and very lovely and supportive neighbours.*
>
> **Interviewee 97, woman of Eastern European heritage**

[51] https://www.ucl.ac.uk/news/2020/jul/levels-depression-and-anxiety-higher-amongst-those-bame-backgrounds-during-lockdown
[52] https://www.ucl.ac.uk/news/2020/jul/levels-depression-and-anxiety-higher-amongst-those-bame-backgrounds-during-lockdown

The table below shows the range of feelings survey respondents experienced since the lockdown started on the 23rd March 2020 in descending order. Within the top ten emotion most commonly felt by survey respondents were: a deep sense of anxiety; distrust; stress; feelings of conflict or confusion; fear or panic; anger or frustration and feelings of being overburdened with additional work. This reflects the ongoing UCL report, of increased levels of anxiety amongst BAMER individuals. The most felt emotion was that of 'mixed emotions' at 61.9 per cent, interestingly the more 'positive' emotions featured relatively low on the table with the exception of 'pleased with a slower pace of life' expressed by 40.48 per cent. Regrettably, nearly 18 per cent of people were dealing with grief of people who had died, which is strikingly high. Whilst we cannot know if these are COVID-19 related deaths, it does appear unusually high for a cohort of BAMER people.

ANSWER CHOICES		RESPONSES	
Mixed emotions		61.90%	52
Anxious		58.33%	49
Distrustful of the Government/media		50.00%	42
Pleased with a slower pace of life		40.48%	34
Stressed		39.29%	33
Conflicted or confused		33.33%	28
Lonely/ isolated		33.33%	28
Afraid or panicked		32.14%	27
Angry or frustrated		32.14%	27
Feel burnt out from working from home/working alongside other responsibilities		30.95%	26
Finding gratitude and kindness in the coronavirus pandemic		30.95%	26
Increased sense of community		25.00%	21
Happy and contented in household		21.43%	18
Powerlessness		20.24%	17
Coping with grief and loss for people who have died		17.86%	15
In need of lockdown routine to help		17.86%	15
Unsupported or disregarded		16.67%	14
Reluctant or unmotivated		15.48%	13
Other (please specify)	Responses	14.29%	12
Relaxed		13.10%	11
Under pressure to return to work		13.10%	11
Uneasy about relationships		13.10%	11
Unprepared		13.10%	11
Like life is unfair		11.90%	10
Total Respondents: 84			

Commonly expressed amongst interviewees and focus group respondents was that of isolation, which was experienced where there was:

- an absence of technology;

- a disability;
- poor housing conditions;
- financial insecurity ;
- language or communication barriers;
- mental health;
- newly migrated;
- Ill-health;
- being a carer;
- racism and
- experiencing or experienced domestic abuse.

Isolation feelings were expressed by these interviewees.

> *I can only watch TV. I would've loved to talk to friends but I'm reluctant to call others because my mobile is low in credit and I can't top up at the moment. I've tried but the shop said my top up card is invalid . . . I want to feel being cared for. The NHS hasn't sent me anything but my friends have received letters from the NHS. I'm a cancer patient, 83 and live alone. I don't know why I'm not on their list as an vulnerable-elderly person.*
>
> **Interviewee 76, man of Chinese heritage**

> *It was a struggle. We were nervous, scared and lonely. We lost our appetite. It was also difficult to keep a healthy diet.*
>
> **Interviewee 65, a woman of Sudanese heritage**

> *I have felt very lonely and scared. I did not have a routine as I spent all my time in the flat. I cannot do heavy housework due to arthritis and back pain. However, I kept the house cleaned little by little and watched TV a lot.*
>
> **Interviewee 104, a woman of Portuguese heritage**

The importance of access to technology and Wi-Fi/broadband was a major part of people maintaining a sense of wellbeing, whether it was speaking to friends, family, accessing work, schoolwork, or entertainment. For most people they expressed the relief of having technology, being able to speak to friends and family in the UK and abroad, passing the time, searching on the internet, feeling connected to the world. **Interviewee 160**, captures some of the ways she uses the internet.

> *Mental support for those who don't have family and friends. Support groups, chat groups, online network support group. Mum's forum. A platform where anyone can go to with any issues however big or small. Which then can be signposted to relevant agencies/organizations. Alternate support if cannot access online. Supporting the vulnerable, lonely, isolated people. Flagging them up who might require assistance during pandemics. Whether it be mental/emotional support, welfare checks, assistance with shopping, meds delivery etc.*
>
> **Interviewee 160, woman of Arab heritage**

For those who did not have data on their phones, technology to access video calling, internet services or even the possibility of regular phone call the sense of isolation was profound.

> *We're very frustrated and struggling a lot with current situation. Don't understand why we're not eligible for any support. All those rules don't make any sense. Our daughter friend who lives only with mum got laptop, my daughter didn't (their financial situation is better than ours). Where is a fairness in all of that? We're left alone, with no support.*
>
> **Interviewee 98, a woman of Polish heritage**

> *I can only watch TV. I would've loved to talk to friends but I'm reluctant to call others because my mobile is low in credit and I can't top up at the moment. I've tried but the shop said my top up card is invalid.*
>
> **Interviewee 76, man of Chinese heritage**

Individuals who are on the peripheries of support systems are further isolated and face increased levels of anxiety. **Interviewee 85**, an asylum seeker is under incredible stress with his living situation becoming progressively untenable, buying food and credit for his phone increasingly difficult, his inability to navigate within the UK's systems and his inability to speak English is leading to his deteriorating mental health.

> *I have felt alone and so depressed. It is really difficult time for me as asylum seeker. I feel vulnerable, during the lockdown because, I don't have knowledge and life skills in the UK. I don't have English knowledge either. The National Asylum Support Service (NASS) regarding finance support for Asylum Seeker is very low. I can't afford to buy enough food, put credit on my mobile phone, pay for public transport for going to my appointments at hospital or GP and so on. I cannot be relaxed. Our hostel is overcrowded and not safe. I am spending a lot of time at home and feel my mental and physical health condition have been deteriorated.*
> *In my opinion poor people particular, Black, Asian and minority ethnic people have been mostly contracted coronavirus because of their poor live condition.*
>
> **Interviewee 85, man of West Asian heritage**

The Runnymede Trust survey[53] uncovered that there was a significant number of respondents who had been victims of racially motivated attacks (verbal and physical) or treated unfairly. There are direct links to impacts of racism on mental health, particularly on the young[54]. **Interviewee 125** explains how she and her daughter have been impacted by racist prejudice surrounding COVID-19.

> *Also, my daughter has experienced bullying in her school because of her Asian features. Children have taunted her about having coronavirus and have coughed over her saying that they will give it back to her and blaming her for it. My father in law also said similar things to me, saying that the coronavirus is from us and that they must keep away from me and my daughter in the home. But when he smokes he doesn't keep his distance from me.*
>
> **Interviewee 125, BAMER woman**

Inequalities and poor outcomes in the face of COVID-19

[53] https://www.runnymedetrust.org/uploads/Runnymede%20Covid19%20Survey%20report%20v3.pdf
[54] https://youngminds.org.uk/find-help/looking-after-yourself/racism-and-mental-health/

This research has identified risk factors which points to disparities for some BAMER individuals in the face of COVID-19. Of course, the relationship is complex. The Runnymede Trust's *State of the Nation* report[55] states that poverty, health inequality and poor housing conditions impact BAMER communities hardest. These groups can also be among the poorest of socio-economic groups and more likely to be at the frontline of this crisis in low-paid and precarious work. These factors need to be explored further. The Public Health England analysis and ONS data suggest that there are strong associations between 'economic disadvantage and COVID-19 diagnoses, incidence and severe disease'.[56] Whilst this report touches on the impact of these issues on contracting of COVID-19, this correlation is largely out of scope of this research study but warrants further exploration. However, there are some observations that can be made from the findings which could make a person more vulnerable

Financial

The Runnymede Trust conducted a survey which they used for the basis for their report, *Over-exposed and under-protected*[57]. They showed how '[t]hree in ten BME people (32%) reported losing some income during lockdown, compared with just over two in ten white people (23%)'. They also reported that just over half of white people (54%) reported that they had not been affected financially by the COVID-19 crisis and lockdown, compared with BAMER people, where a third (35%) said that they had not be affected financially. For some of the interviewees the impact of financial insecurity was very much their reality.

> *My partner is self-employed, so his work over this period has been non-existent. More info and financial advice regarding self-employment would have been useful early on. We did find and understand the information, but it is not straightforward, so to keep stress levels down more info on that would have been good.*
>
> **Interviewee 41, No identifying information recorded**

> *I'm worried about being infected and loss of income as I've lost my job just before the beginning of lockdown. Feeling upset as I hear the numbers of deaths and infected cases. I wasn't allowed to see my grandchild and missed her so much. I had to do more housework and cooking.*
>
> **Interviewee 80, a woman of East Asian heritage**

> *Have needed help with finances . Friends and family abroad have sent them money. No recourse to public funds. My husband applied for benefits for first time in late February and now that is helping – but no allowance for me.*
>
> **Interviewee 127, woman of Arab heritage**

> *I have been feeling ok but worrying the business which has been very low and slow since the lockdown.*
>
> **Interviewee 74, woman of Chinese heritage**

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55 https://library.oapen.org/bitstream/handle/20.500.12657/22310/9781447351269.pdf?sequence=4&isAllowed=y

56 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

57 https://www.runnymedetrust.org/uploads/Runnymede%20Covid19%20Survey%20report%20v3.pdf

> *I called the mortgage company, and they can hold payments for 3 months, but at the end of that you end up paying more so it doesn't help. We also applied for financial help. I didn't know how they calculate it, but we didn't get anything so that didn't help.*
>
> **Interviewee 2, woman of Arab heritage**

> *Currently, I'm living on Universal Tax credit. I found food packages from the local foodbank very useful. Once a week I had ready dinner, besides that I was getting baked beans, fruit, soups in cans, tuna, eggs, toilet paper, soap, cereal. Thank you for that.*
>
> **Interviewee 97, a woman of Polish heritage**

> *We have financial problems, quite a lot of debts, including unpaid rent, large council tax bill, council counted twice my husband earnings, it's hard to resolve this as we struggle with communication with the council. In spite of all ongoing issues we still haven't been offered any food packages, which makes us very upset as we've seen people in better financial situation receiving some . . . We're at risk of eviction, as our flat was sold and new landlord gave us notice before the COVID. We also had problems with paying our rent over past few months as we were given wrong bank details. We have only been given current details on 15 July and asked to make all payments, which we can't afford at the moment as my husband lost his main job.*
>
> **Interviewee 98, a woman of Polish heritage**

Interviewee 97 had the additional worries around her residency as well as her financial situation.

> *I have Polish television and prefer to watch something else than information about the virus. I live in one-bedroom flat which is in very bad condition and landlord doesn't want to do any work there. It's very cold here during the winter and electric heating cost me fortune, even £200 per month. After paying all my bills I have only £8 left for a day. I can't afford better flat and moving. I can't also afford to apply for Polish Passport (which expired) so I can apply for the residence status by the end of the year, which makes me very anxious as I haven't been able to go back to Poland for nearly 7 years.*
>
> **Interviewee 97, woman of Polish heritage**

Being a survivor of domestic abuse was an aspect that **Interviewee 124** faced alongside her difficult financial situation, who had recently escaped from her husband.

> *Have felt very alone, so lonely, and uncertain. Have no friends, very scared to begin with. Worried about whether to wear masks, but settled down after a bit, and got used to it. Routine is not the same, in the house all the time . . . Using an iPad, but it's hard. Worried about going out so got masks. All my assets are in the name of husband so no money, and for a while we had no food in the house. I was so grateful for the food deliveries, and am now getting it from the Food Bank.*
>
> **Interviewee 124, BAMER woman**

Mitigating risk and negative impacts of lockdown

Interviewees and focus group participants recognised the need to find strategies to battle possible negative impacts of lockdown and COVID-19. A lot would depend on the BAMER individual's:

- social, community and/or religious networks;
- working and housing conditions;
- childcare arrangements;
- free time;
- if they worked;
- financial security;
- access to technology and Wi-Fi/Broadband and the ability to use it;
- disability;
- age;
- family dynamics;
- ability to speak English and
- mental and physical health.

The ability to control any number of these factors could mitigate negative impacts of COVID-19 and the lockdown, for others these factors were out of their control. People were often clear about what resources or support would be beneficial through lockdown.

> *I don't know but I would not prefer any more information about Coronavirus. Being alone for long time was very hard. Seeing or talking to people might have helped.*
>
> **Interviewee 64, a woman of Syrian heritage**

> *I would have liked it if someone would have rung me to find out how I am doing and to reassure me that all is fine. When you hear of so many people dying it's scary.*
>
> **Interviewee 16, a man of Arab heritage**

> *Confidence gone, scared to go out used to four walls like own prisoner. Before always out and about routine always out just come home for lunch then go out again. Now panicky as life had changed total contrast to what I was before. Need to build my confidence. If I continue like that I will deteriorate. Children centre calling welfare check with family members. Chased up if not answered and boosted up my confidence. Telling me to go out for half hour at a time and build up. Go out necessary but told to meet up with friends and children friends build up confidence.*
>
> **Interviewee 45, a woman of Bangladeshi heritage**

Others were in a position to make the best of the lockdown.

> *I've tried to get back to old hobbies, to keep myself away from TV reports. I've started reading again and making handmade clothes and altering my old ones. I used to alter clothes, but didn't have time when I was working. I'm also talking to friends and family from all over the world for most of the day. I've got the chance to see everyone and speak to them.*
>
> **Interviewee 30, a woman who identified as of African heritage**

> *Exercising, walking, field at back which is people free. Read a lot, phone and video calls friends. I have a lovely circle of friends who are 70s and over calling them and checking up on them most of their spouses have passed away. We were all nurses in Brighton . . . as I have family and friends, keeping well gentle walk not mixing with people.*
>
> **Interviewee 43, BAMER woman, no information available**

> *Having faith, religious, praying for protection and keeping good diet and exercise. It is scary to know BAME being at high risk and we live in our multi generation house. I have my children, their wives and grandchildren in the house (three generation).my boys go out to work.*
>
> **Interviewee 42, a woman of Bangladeshi heritage**

> *I have been speaking with my daughter a lot on the phone, but I didn't have contact with anyone else. Getting out to my allotment everyday has helped me.*
>
> **Interviewee 1, no information available**

Some were in contact with organisations, voluntary and religious groups who were able to support individuals and families.

> *I think the help from Migrant Help at the beginning calling me to see how I am doing was good. That has stopped. Also, Voices in Exile called me a few times mainly about food delivery.*
>
> **Interviewee 12, a woman of Zimbabwean heritage**

> *It was a difficult time . . . I was totally isolated in the house with my family not seeing anyone. Like everyone else I had concerns about the virus, and on top of that there was the anxiety of being isolated all that caused stress. But we tried to find things to do and keep ourselves busy at home. The Network of International Women for Brighton and Hove had a big role it involving us in activities that was productive and that had a positive effect and helped. It also helped that I am a strong person and I am religious and that enabled me to cope. The most difficult time was at the beginning of lockdown, then we got used to it and we coped.*
>
> **Interviewee 137, a woman of Arab heritage**

> *. . . for a while we had no food in the house. I was so grateful for the food deliveries and am now getting it from the Food Bank.*
>
> **Interviewee 124, a woman of who identified as a white South American**

The data collected through surveys, interviews and focus groups perhaps highlighted the depth and breadth of information shared by BAMER people, of which only a fraction was showcased. Further research and analysis to explore the diversity of experience within Brighton and Hove BAMER citizens city development work would identify details of an asset-based approach to enable individuals feel empowered in their lives. A broad range of BAMER-led, community ,and voluntary sectors, alongside religious groups who can help reach the most vulnerable to look at befriending schemes, food banks, digital inclusion schemes (including broadband), benefit and health advice to build community assets.

Appendix

All Question Interview: Interviewer's guidance notes

WELCOME SCRIPT

Interviewer: *Thanks for agreeing to this interview. This project is examining the impact coronavirus has on BAMER people in Brighton and Hove.*

Interviewer: *We have been asked to conduct interviews by the Clinical Commissioning Group/NHS.* This project is examining the issues surrounding coronavirus has on BAMER people in Brighton and Hove. .

Interviewer: *Everything you say will remain anonymous/private, no one outside of this project will be able to identify you in the report.*

Interviewer: *Are you still happy with that?*

PART 1: NHS Services

The first element of the project assesses the relationship that BAMER people have with NHS services.

Interviewer: *What is your experience using the NHS?*_____

_____

_____

Prompts: *Thinking back over the last year or two, what were the different NHS services that you used? Were the services good, did you get good care? How were you treated by the staff?*_____

_____

_____

_____

_____

_____

Interviewer: *Did you have any NHS appointments cancelled during the coronavirus lockdown? Or did you cancel any NHS appointments? Why did you cancel it?*

_____

_____

Interviewer: *By missing your appointment(s) did it impact you negatively?*_____

_____

_____

Interviewer: *Have you or anyone in your household had coronavirus?*

IF THE PERSON OR THEIR HOUSEHOLD DID NOT GET CORONAVIRUS, GO ONTO PART 3.

PART 2 Experience of coronavirus

This part asks people who have tested positive with coronavirus or believe they had the coronavirus symptoms, whether they had underlying health conditions, about their recovery, what services they accessed and the experience of those services accessed.

Interviewer: *Who in your household has caught the coronavirus? [**Prompt:** Was it you, someone else in the house?]* _____

_____

Interviewer: *Did you/they get a test?* _____

_____

_____

Interviewer: *Was anyone else in your household affected?* _____

_____

_____

Interviewer: *Did you/they have any underlying health conditions? [**Prompt:** For example diabetes, heart condition, respiratory, asthma, etc.]* _____

_____

_____

_____

Interviewer: *Did you/they get a letter from the NHS to say you/they should stay at home? [**Prompt:** If appropriate ask them what the condition/illness/disease it was.]*

_____

_____

Interviewer: *Did you/they get treatment for coronavirus from the NHS? What kind of support did you get? How was the treatment?* _____

_____

_____

_____

_____

Interviewer: *After you/they recovered from coronavirus, did you have any lasting illness from coronavirus?* _____

_____

_____

PART 3 Employment situation

This section asks about your employment situation before the lockdown and during the lockdown.

Interviewer: *What was your employment situation before the lockdown? [**Prompt:** Were you self-employed, retired, carer, zero hours contract, etc.].* _____

_____

_____

Interviewer: *Did you have to work outside the home during lockdown? Were you an essential worker?* _____

_____

_____

If the interviewee did not work outside the home during lockdown you can skip the questions in part four.

PART 4 Working during coronavirus lockdown

The section is relevant only for those who worked outside the home as an essential worker, which considers how BAMER people travelled to work, choices about attending work, feeling safe at work and disparity in treatment at work and levels of risk.

Interviewer: *How are you travelling to work? How did you to travel to work before the lockdown?* _____

_____

_____

Interviewer: *Do you feel safe at work? Do you think you were expected to take higher levels of risk than your white colleagues?* _____

_____

_____

_____

What PPE did your employer provide? Did your employer carry out a coronavirus risk assessment? _____

_____

_____

Interviewer: *Did you get the PPE (personal protection equipment) you needed?*

_____

_____

PART 5 Information and concerns

The fifth part explores how BAMER people access health information, preferred communication styles, how information and messages are consumed, impact of the lockdown and sources of advice that might better support them.

Interviewer: *Where did you get your information about coronavirus? [**Prompts:** Government briefing, social media, WhatsApp groups, family, council, community/ voluntary groups, religious groups, newspapers, tv, radio, etc.]* _____

_____

_____

Interviewer: *How would you likex to have received information from the NHS? [**Prompts: Would you like clearer information? Plain language, pictorial, Easy Read, in another language other than English, website, WhatsApp messages, texts, emails, leaflets, letters, billboards, helpline, etc.**]_____

_____

_____

Interviewer: *What are the main symptoms of the coronavirus?* _____

_____

_____

_____

Then confirm to the person through the NHS definition what the main symptoms of coronavirus are.

Interviewer: *Do you and your household feel you are taking more risks than you would like to? Tell me more about that?* _____

_____

_____

_____

_____**Interviewer:** *What would you do if you or a member of your household got sick from the coronavirus? [**Prompts:** Would you visit/speak to your GP, go to the pharmacy, call 111, go to the hospital, call friends and family for help, go to a traditional healer, contact the council, etc.]*

_____

_____

_____

_____

_____

Interviewer: *How have you felt since the lockdown has started? Have you any concerns about the coronavirus? [**Prompts:** Have you felt positive, negative or had mixed feelings about it? Have you felt happy to be in your homes or has it been difficult? Has is been stressful or relaxed? How have your household found it? Did you feel alone or scared? Did you have a routine? Did you feel you had to do more to do in the house, did everyone in the house work together to get all the work done?]* _____

_____

_____

Interviewer: *What sort of things would have helped you/would help you during this coronavirus pandemic? [**Prompts:** Would you have liked more information about keeping safe for the coronavirus, learning how to get advice on issues such as: libraries, keeping family safe at home, keeping fit, IT lessons, ESOL lessons, help with bills and benefits, racist abuse, someone to talk to.]* _____

_____

_____

Interviewer: *How are you keeping yourself well? [**Prompts:** Exercise, talking to friends and family on the phone, on Zoom/WhatsApp, etc., spending time on your hobbies, doing things you like to do. Is it difficult to keep yourself well? What would help you?]*

_____

_____

Interviewer: *What can the NHS do to support you?* _____

_____

_____

Ending the interview

Thank the interviewee for their time and participation and let them know that you value their contribution.

Monitoring question

Please fill in the equalities monitoring section below, only complete what is reasonable and appropriate and leave blank any unanswered questions.

Next step

Next steps are explained at the end of document.