

Impact of Covid-19 and Inequalities

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Introduction

We were asked to contribute to an equalities focused Impact of Covid-19 review by HEAR Equality and Human Rights Network on the 23rd of March. The timeframe for submission was short, which limits the completeness of this report, and so this report is illustrative in nature and does not intend to be exhaustive.

Scope of this work

Since the pandemic began around a year ago we have collected detailed, largely qualitative experiences from around 2,500 people in Richmond, through a wide range of methods. Some of these were semi-structured and person-led in nature, others were highly structured and focused on emerging issues or areas of concern, and some were unsolicited comments gained from broad outreach and from people contacting us. Much, but certainly not all of this work is published in the following reports:

- [Health, Care & Wellbeing Experiences in Richmond During Coronavirus](#)
- [Young People's Wellbeing During the COVID-19 Crisis](#)
- [Experiences of Maternity Services in Richmond During Coronavirus](#)
- [Dentistry Services During Coronavirus](#)

Our outreach and engagement work included specific focus group type discussions with community groups including at:

- Black History Month event
- LGBTQ+ History Month event
- Learning disabilities Carer's events
- Discussions with people with disabilities and long term health conditions
- engagement with young, working age and older people

As a result of this broad approach, we have confidence that these findings represent a reasonable understanding of the range of issues facing our community, and in some areas we have very detailed information about the scale and impacts of these issues.

Except where it is specifically referenced, the reader should assume that the findings detailed in this report are sourced from a group that is broadly representative of the community in Richmond. It is possible that the issues we have identified in Richmond may not be reflective of the key issues in other areas of London, or indeed nationally.

Key findings

Inequalities

Our work identified particular inequalities relating to:

- digital access and digital services,
- caring roles,
- living alone,
- people living alone,
- access for those shielding or with perceived high risks from the virus,
- young people,
- financial exclusion,
- Maternity care,

- The LGBTQ+ Community,
- Challenges for the Black and Minority Community,
- Challenges for people with English as an additional language or with lower literacy, which intersects with other difficulties.

These issues exacerbated each other and some protected characteristics also created additional pressures on these groups of people.

Digital divide

Digital exclusion is not limited to having access to a device and the internet. Many people had both the equipment and the skills to join video calls or send emails but lacked the skills, support or knowledge to undertake new tasks online, such as booking shopping or appointments. Bridging the digital divide requires a combination of:

1. supporting people to access devices and internet access,
2. supporting people to develop new skills necessary to access support online,
3. providing ongoing support and information,
4. continuing to provide support through traditional methods as digital care will not always work or be effective for all.

Those who were not able to use technology were more reliant on community support to access food and essential shopping. These people felt that they lacked choice over their food and supplies or said that their dietary needs were not being met:

“No one in this crisis is mentioning elderly people like me with special dietary needs... it would be hard for me to send someone to do my shop and I don’t know how to order online” (Comment received via an online survey)

Those living alone are less able to adapt and develop the new skills that they need to engage online and remotely. Social distancing reduced the support that people could access and many people, particularly older people of south Asian descent, relied heavily on family members for this support pre-pandemic ([Health, Care & Wellbeing Experiences in Richmond During Coronavirus](#)).

For those with English as an additional language or with lower levels of literacy, accessing support digitally is also very challenging (see English as an Additional Language and Literacy, page 10)

Key learnings and recommendations

People must be supported to access care remotely, through:

- a. easing of access to devices and the internet,
- b. facilitating the development of new skills necessary to access support online,
- c. provision of ongoing support and information,
- d. provision of spaces where people can access remote care privately.

Older people, particularly those living alone, people living with parents or in shared accommodation, and those with English as an additional language have expressed particular needs for digital support. However, this may not be an exhaustive list.

Digital by default

The move from face to face to digital by default for accessing services includes a range of support from social care to NHS care. Many people contacted us to share their experiences of accessing support digitally and they did so through a range of methods (postal and online surveys, video and phone conference calls and by contacting us directly).

Our findings show that people valued not having to visit clinical environments, particularly where they perceived themselves to have high risk from the virus. For some it was convenient around home working or where it provided them with the care they needed in a convenient or more timely manner.

Despite the perceived benefits, these were undermined where virtual appointments did not run to time or where they did not meet people's needs.

Many people wanted to see their GP or psychiatrist, and either lacked trust in digital consultations or felt that they were less effective. Some people felt that the digital consultation discriminated against the elderly and those with disabilities as they were less able to engage with them effectively. It is particularly notable that these views were not restricted to those who are digitally excluded but were also voiced by those with physical or sensory impairments and those with more complicated or significant medical conditions ([Health, Care & Wellbeing Experiences in Richmond During Coronavirus](#)). Younger people also frequently struggled to engage with digital services (see Young People page 5)

The need to set up new accounts for booking appointments, order prescriptions and access support and services online presented a barrier to those who were digitally excluded.

Key learnings and recommendations

While virtual access to health and social care has had positive aspects throughout the pandemic, it is crucial to bear in mind that digital support will not always work or be effective for all and is not inclusive.

1. Face to face appointments are still needed where assessments, tests or procedures are required, or where it is necessary to build trust and rapport. For these services, digital should be the exception rather than the default.
2. Those excluded include people who lack the skills and technology as well as those who lack the privacy to engage remotely. Once safe, in person care and offline access must resume and remain an option that people can choose. Digital by default must not become exclusively digital.

Carers

Carers faced a multitude of challenges during the pandemic with support reducing for both them and their cared for person.

- **Reduced respite.** Most respite care stopped and the reduction, in most cases the halt, of face to face support removed the respite that carers would get from their cared for person being out of the house.

- **Increased burden of care.** With reduced support for the cared for person, carers often had to take on care coordination roles for their cared for person.
- **Reduced support for carers.** As well as support for carers for people ending during the pandemic, much of the support that carers could access for themselves also stopped.
- **Changes to living and care arrangements.** Many people, particularly those living alone or in communal arrangements moved in with carers during the first wave of the pandemic. Those with high perceived risks from the virus were also more likely to decline domiciliary care due to perceived risks of carer workers bringing the virus into their homes. This led to many carers taking on additional care burdens. Whilst this provided greater social support, it also placed additional strain on carers.

Carers largely spoke to us about the needs of the person that they care for which masks the extent of the impact of the crisis on carers.

In addition to this, carers faced some significant challenges with accessing the vaccine within tier 6 arrangements. We heard of policies being applied inconsistently and arbitrarily to carers. In one instance only one parent carer was offered a vaccine despite their physically disabled child requiring the support of both parents. In other instances, people were told that they didn't meet the threshold. This was particularly true of those who had chosen not to claim carers allowance.

Key learnings and Impact

We identified challenges for carers to access vaccinations stemming from incomplete registers of carers and strict criteria. As a result of our interventions, communication to carers was prioritised and the implementation of the criteria was significantly less prescriptive than it might otherwise have been. This went some way to reducing the inequalities that were felt amongst this group ([Health, Care & Wellbeing Experiences in Richmond During Coronavirus](#)).

The burden of care has been greatly increased during the pandemic. Carers capacity and resilience will have been eroded as a result. Carers will need enhanced support to recover from the pandemic, additional respite care, mental health and emotional wellbeing support and support from care navigators/social prescribers.

People living alone

People living alone experienced additional challenges during the pandemic. Less support within the household meant that they were less able to pick up the new skills necessary to engage online. The reduced contact of living alone exacerbated the social isolation that people experienced, particularly in those communities who could not easily form support bubbles. Whilst this may have been mitigated to some extent by using technology, people living alone had less support to overcome barriers and were more likely to be digitally excluded.

Both of these were particularly true before the introduction of support bubbles in June. People who were shielding were less likely to form support bubbles.

For those in the LGBTQ+ community, the isolation from their community and friendship groups was particularly acutely felt because some people had experienced breakdown of family support ([Health, Care & Wellbeing Experiences in Richmond During Coronavirus](#))

Key learnings and recommendations

Support bubbles provided vital support for people living alone. Some people living alone, particularly those from the LGBTQ+ community where this is more prevalent, however were unable to form support bubbles as others had already done this.

Shielding and those with higher perceived risks from the virus.

People who were shielding or who were at higher perceived risks from the virus were hesitant about re-engaging with face to face activities (e.g. essential appointments, shopping, and socialising).

People with the same condition had different perceived risks due to things like their overall perceptions of their health and risks from other factors such as age or ethnicity. As an example people with well controlled diabetes, active lifestyles and without co-morbidities were likely to perceive their risk as lower than people with the same diagnosis but lower activity levels or those from an ethnic group with higher risks from the virus.

Whilst shielding, people, and those with high perceived risk experienced similar hesitancy, did not always have the same access to support. For example, shielding people had access to preferential shopping, whilst those with self-perceived high risk did not. This caused an inequality between those who were judged to be clinically extremely vulnerable and those who judged themselves to be clinically vulnerable.

These perceptions were usually very rational and in some cases were later borne out by changes to shielding guidance or JCVI vaccination guidance.

The inequality that this created was further exacerbated by other factors. Those with good digital access or who were known to services were for example often able to access support from friends, neighbours, professionals or the voluntary sector. We saw a great many people with unmet needs of this sort coming forward throughout the pandemic in response to our door to door distribution of printed material offering support.

People who were shielding or had high perceived risks told us that understanding the risk (e.g. the prevalence of the virus locally) and the infection protection and control measures in place to keep them safe were key to enabling them to re-engage with face to face activities.

On our advice, the CCG launched a communications campaign to explain these factors. Later in the pandemic, people often told us that they expected clinical environments to be safely managed and this reduced their hesitancy. The near absence of community cases over the summer was also an important mitigation for people with high perceived risks and people advised to shield. These people however remained concerned that other environments, particularly public transport, shops and community spaces are not sufficiently safe due to the lack of social distancing and effective control measures and the high prevalence of the virus in the community ([Health, Care & Wellbeing Experiences in Richmond During Coronavirus](#)).

Impact

People who were at higher risk from the virus told us that they were worried about their safety when traveling to or attending appointments. Understanding the control measures in place made them more confident about attending appointments.

We shared this key finding with the NHS who launched a communications campaign video explaining how people will be kept safe from the virus which we believe addressed this.

Young people

We spoke to around 350 young people during the first lockdown. Overall young people were very resilient. The pressures that they faced likely changed dramatically over time as things like the uncertainty around exam results developed.

People aged 15 and 17 and particularly females reported lower wellbeing which was driven by not being able to see friends and loved ones, an increase in school stressors and having too much “*time to think*”. Whilst we can only speculate it is notable that these were groups where young people were moving into exam years. Conversely those aged 13, 14 and 16 reported lower levels of school related stresses.

For young people with health conditions and/or disabilities, the service they received deteriorated significantly. Things like child and adolescent mental health services largely ceased and people experienced difficulties with accessing medications. Where previously face to face services ceased, young people relied much more heavily on their GPs who provided continuity. The capacity of GPs was however challenged over the pandemic which caused young people significant challenges in managing their conditions.

Young people, whilst often thought of as digitally literate or “digital natives” often found digital access a significant barrier for many of the same reasons cited by older age groups. In addition, younger people were more likely to lack the privacy needed to access care online as a reason for not engaging with digital services and support.

Throughout the Covid-19 pandemic, the above issues have come up regularly in discussions with young people. Exam stress however has worsened throughout the year. Young people at our group Youth Out Loud! lamented the accumulated stress arising from frequent changes. Long periods at home to suddenly being back in the class every day once guidelines changed made young people feel uncomfortable.

Young people spoke of a need for more gradual changes, especially for those who have physical or learning disabilities, whose resilience may suffer from additional mental or physical needs. Many have also complained about increased workloads and lack of hope for the future as it's become more uncertain ([Young People's Wellbeing During the COVID-19 Crisis](#)).

Key learnings and recommendations

Young people have had to manage a great deal and whilst there is impressive resilience however for those with needs their support largely ceased. Reestablishing face to face Child and Adolescent Mental Health Care and expanding mental health support programmes in schools should be prioritised.

Should there be further lockdowns, the approach of the roadmap would be welcomed by young people. Indeed a roadmap leading both into and out of school closures would be welcomed.

Financial exclusion

Whilst we do not deal with financial hardship specifically as an organisation, it is clear that it has a significant impact as a wider determinant of health and that it has a direct link to ability to access care. Our colleagues in organisations that provide benefits support report record numbers of people seeking help and a change in who is experiencing financial challenges. Often these people were unprepared for the financial challenges that they experienced, were unaware of what support was available or of how to access it.

One area where we saw marked inequality caused by financial circumstances was dentistry. Our review of 300 people identified a significant inequality in access to dentistry based on ability to pay.

Half of people who could not afford to pay for their care were unable to access routine dental care, 16 times more than for those that could afford private treatment. Whilst things were better with urgent and emergency care, people were twice as likely to be able to access urgent or emergency care if they could pay (1 in 6 vs 1 in 3). ([Dentistry Services During Coronavirus](#))

Maternity care

The pandemic had substantial impacts on pregnant women and expectant families. Much has been written elsewhere about maternal mental health during the pandemic. We commend the work of the wider Healthwatch Network on this but note that our work in this area focussed on maternity care ([Mental health and the journey to parenthood](#)).

We collected the experiences of over 400 women and families during the pandemic. Whilst this sample was representative of the diverse community, it did not highlight significant differences based along the lines of protected characteristics. Indeed, the experiences along these groups were largely consistent.

Language however was a significant factor in face to face interactions. For those with English as an additional language, not being able to be accompanied by partners created significant difficulty with communication and increased people's anxiety.

“my English not first language and I needed my husband to explain about things when they asked me they didn't allowed him and I was lost that day and didn't know what to answer when they was filling the file... I'm worry because I have another appointment with the midwife and I hope it's not gonna be like my first experience, even I was asking some questions she was not answering”

Interestingly, perhaps because information provided through other means like interactive video calls could be accessed from home with partners present this feedback was limited to face to face appointments where partners were unable to attend.

There were a great number of other impacts from partners being unable to attend. These were disproportionately felt by those women who had had more traumatic or complicated births because they were separated from their partners for longer whilst in postnatal care

and because they often needed additional non-clinical support (e.g. someone to look after the baby whilst mum self-cared). Those with pre-existing children struggled without being able to see their other children whilst in postnatal care ([Experiences of Maternity Services in Richmond During Coronavirus](#))

Key learnings and Impact

We made specific recommendations to maternity care providers and supported workshops with their staff to discuss how they could be implemented. We are awaiting updates on how these recommendations have resulted in improvements and learning.

Inequality for LGBTQ+ People

LGBTQ+ people spoke about higher mental health needs during the pandemic and lower levels of support from their community. There are more people within this community that lack familial support and more people that live alone than in the wider community which makes the support of friends, the LGBTQ+ community and workplace acquaintances more important as sources of support and information. Similarly, LGBTQ+ people are less likely to have the practical and financial support that comes from a supportive family and so are less able to mitigate the impact of things like job losses and relationship breakdown - which we know were more common during the pandemic.

The restrictions had a disproportionate impact on the LGBTQ+ community.:

- The closure of LGBTQ+ safe/friendly amenities and spaces (such as pubs, bars and cafes) during the pandemic had a particularly chilling effect on the community and reduced the opportunities to seek this support. There was a strong desire amongst the community for opportunities to meet people in person.
- Whilst the experience shared many similarities with that shared by other people who lived alone, support bubbles were mentioned less commonly by the LGBTQ+ community. It may be that this links back to the lower levels of family support or to the higher levels of people living alone.
- Restrictions on attendees for funerals meant that wider friendship groups were not able to come together around the death of their friends. Some people spoke about bereavements therefore being more difficult during the pandemic as the community support was greatly diminished by this.

LGBTQ+ people are disproportionately affected by mental health needs compared to the wider population

(<https://www.datarich.info/groups-and-communities/sexual-orientation>). Most people, across all gender identities and sexualities reported that remote support was both more common and less helpful than face to face support. In conjunction with the reduced social support that has come from the pandemic this creates a significant adverse environment for people from LGBTQ+ backgrounds.

Key learnings and Impact

People told us that the number of LGBTQ+ friendly/safe spaces in South West London (such as pubs, bars and saunas) had reduced significantly in the years prior to Covid-19 and that those that remained had been closed by restrictions for a considerable time. There was a strongly felt need to protect the remaining amenities which had been significantly financially impacted by the restrictions and to develop other ways of bringing

the community together. Council support for outdoor events and consideration of community needs would be valued by the community.

In moving forward, additional support, or additional promotion of existing support, around the wider determinants of health (e.g. financial and housing support) and mental health services could be channelled through LGBTQ+ support organisations and online spaces. It is crucial to maintain and support LGBTQ+ safe spaces, whether online or in person, as those spaces are a core part of the community support system. While the pandemic has made it difficult to preserve in-person spaces, if nothing else, it is possible to offer support to awareness events and online spaces.

Black and Minority Ethnic Communities

Speaking to members of the Black community of Richmond in November 2020, we found that there was a lack of multicultural awareness and celebration in the borough - and much to celebrate. In addition, many people were unaware of the opportunities available to them across NHS, care and wider community support and therefore unable to take advantage of them.

The majority of people we spoke to did not feel that they had issues accessing healthcare in the borough. Many of the problems that people did experience echoed those seen across the whole population such as issues with accessing an NHS dentist. The effects of COVID-19 and subsequent lockdown measures also had an adverse effect in accessing healthcare services, some participants felt reluctant to contact their GP for fear of burdening the NHS.

One person highlighted difficulties accessing CAMHS support for their child, a problem which has long been identified in the borough of Richmond.

“Accessing mental health for my young son was a traumatic experience”

This person said that their child’s mental health and behavioural issues may have been missed because the child was stereotyped as a Black and aggressive child rather than as a child with needs. This perception may have exacerbated the child’s behaviour and further prevented them from accessing mental health support. Whilst we do not seek to downplay the role that racial bias may have played in delaying access to care, it is also important to recognise that very high thresholds for accessing mental health support for young people have previously been cited as a barrier to accessing this care across the community as a whole ([Improving Emotional Wellbeing for Young People](#)).

Key learnings and Impact

Across the country, Black and Minority Ethnic communities are hardest hit by the pandemic and by health conditions such as mental health and wider determinants of health, such as financial issues (see the UK Parliament’s report on the [Impact of COVID-19 on different Ethnic Minority groups](#)).

More opportunities for celebrating and learning about Black history, ideally by providing grassroots funds for members of the community to lead this, would enable people to engage and provide an opportunity to understand and address inequalities and to raise awareness of the support that is available.

English as an additional language and literacy

People highlighted that learning and language difficulties also affect minority communities disproportionately, in particular dyslexia and having English as a second language. These were particularly challenging for people starting life in countries where things like dyslexia are not widely recognised or even stigmatised as they often will not have received support for this.

These people experienced inequality and difficulty across a range of things during the pandemic from helping children with home-schooling and homework to accessing support and information for themselves and their families. This has led to some people feeling depressed and losing confidence as well as being less able to access care and support leading to significant disadvantages.

People told us that friendship groups and social prescribing activities where they could connect with individuals in a similar situation had had a very positive impact on their wellbeing and inclusion within a community. It also allowed them to practice speaking English in a safe environment and to exchange information about services available to them.

Key learnings and recommendations

The needs of the English as an Additional Language community should be taken into account when designing services, as while they are not a protected characteristic, they do suffer from exclusion on a variety of levels.

Engagement with support and friendship groups should be taken up or maintained at a local level, as it allows for the creation of bonds and the spread of valuable information. Social prescribing and nature prescribing programmes should be encouraged within the community as well.

Further exclusionary characteristics such as literacy, financial and mental health difficulties sometimes overlap with this group, and should be taken into account when designing services.

Summary of key learnings and recommendations

1. The digital gap should be bridged through ease of access to equipment and skills. Whenever possible, in-person care must remain an option.
2. Additional support must be made available to carers, in the form of additional respite care, mental health and wellbeing support, and support from social prescribers.
3. Greater communication to targeted groups, such as young people or clinically vulnerable people, about measures in place and expected changes, would greatly help reduce anxiousness.
4. Extensive capacity increase for mental health services across the borough is necessary, to reduce the backlog of care and support the people who developed mental health issues during the pandemic.
5. The promotion and protection of safe spaces for minority groups should be prioritised.

Further information

Healthwatch Richmond

82 Hampton Road, Twickenham, TW2 5QS

Registered Company (08382351) and Charity (1152333)

Visit: healthwatchrichmond.co.uk

Call: 0208 099 5335

Email: participation@healthwatchrichmond.co.uk

Facebook: [@healthwatchrichmond](https://www.facebook.com/healthwatchrichmond)

Twitter: [@HW_Richmond](https://twitter.com/HW_Richmond)