

Rapid Evidence Review: Inequalities in relation to COVID-19 and their effects on London

21st September 2020

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Executive summary

This report provides the outcomes of a rapid evidence review that was commissioned by the Greater London Authority. The objective of the review was to document and understand the impact of COVID-19 (in terms of both health and the broader impacts on existing social and economic inequalities) on those with protected characteristics, as well as those living in poorer, or more precarious, socioeconomic circumstances, paying particular attention to its effect in London.

We identify substantial inequalities across protected characteristics and socioeconomic position in relation to the impacts of the coronavirus pandemic. This is both in terms of risk of COVID-19 infection, complications and mortality, and in terms of the negative economic, social and psychological consequences of Government policies to mitigate the health impacts of the pandemic. These COVID-19 related inequalities are caused by processes of marginalisation and oppression, which before the pandemic had led to well-documented social and health inequalities, inequalities that have been exacerbated during the coronavirus pandemic.

Disability. Although evidence on disabled people is limited by a lack of data, analyses using death registry data linked to 2011 Census data show stark inequalities in COVID-19 related mortality for people who report experiencing limiting longstanding illness. For example, the rate for women who are limited a lot by a longstanding illness is just over three times as high as that for women who are not limited, once age differences are taken into account. The increased risk for disabled people results in part from their poorer living circumstances and socioeconomic position, associated co-morbidities and vulnerability to ill-health, and increased risks from living in residential facilities. Disabled people are also much more likely to have difficulty accessing crucial services and public health information, and are more likely to feel lonely and have poor mental health and wellbeing outcomes.

Ethnicity and religion. There are stark ethnic inequalities in the impact of the coronavirus pandemic. Even after considering differences in age, geographical factors, socioeconomic conditions, and health, the risk of COVID-19-related mortality compared with White men and women was 1.9 times greater for Black men and women, 1.8 times greater for Bangladeshi and Pakistani men, 1.6 times greater for Bangladeshi and Pakistani women, 1.3 times greater for Indian men, and 1.3 times greater for men in the 'Other' ethnic minority group. There are also substantial inequalities in risk of mortality according to religion, with Jewish people and Muslim people at particularly high risk. Ethnic minority people are also more likely to be employed in sectors that increase their risk of exposure to COVID-19 infection. Ethnic minority people are more likely to have the underlying health conditions that have been linked to increased risk of COVID-19 infection and mortality, which themselves are patterned by the social and economic inequalities they face. We also document similar ethnic inequalities for risk of infection and for the impact of the pandemic on mental health, loneliness, and access to health care, and economic situation. However, crucial is that the patterning of these social and economic inequalities is underpinned by longstanding and enduring structural and institutional racism and racial discrimination.

Gender. The risk of COVID-19 related mortality is substantially higher for men compared with women. In contrast, women have experienced disproportionate economic, social and psychological impacts as a result of the coronavirus pandemic. Mothers were 47% more likely than fathers to have lost their jobs or resigned from their jobs, and 14% more likely to have been furloughed. Women have taken on more childcare responsibilities when working from home, yet more than half of those who needed childcare reported not having sufficient provision in place and that the lack of childcare was a substantial contributor to loss of a job and being furloughed, all of which will have long-term economic consequences. Lockdown has also substantially increased risk of domestic violence and abuse, and

worsening of pre-existing domestic violence and abuse. And women experience a greater impact on their mental health and negative impacts on reproductive healthcare. It should be noted that these findings reflect longstanding gender inequalities, often enacted through sexist discrimination shaped by unequal social structures that are underpinned by longstanding process of patriarchy and misogyny.

Sexual orientation, gender identity and gender expression. There are no data on COVID-19 infection and mortality rates by sexual orientation, gender identity, or gender expression. However, there is evidence of widespread impacts of the coronavirus pandemic on the LGBTQ+ community, particularly in terms of discrimination, loneliness and mental health. Almost four in five (79%) LGBTQ+ people said that their mental health had been negatively impacted by the coronavirus lockdown, and many young LGBTQ+ people report feeling unsafe during lockdown in their current housing conditions.

Socioeconomic position. COVID-19 related mortality rates for the most deprived areas in England have been approximately double those of less deprived areas. There is also evidence of marked differences in risk by occupation, particularly for men, with those in unskilled and manual occupations having a three times higher mortality rate than those in professional occupations. Occupation is also related to risk of job loss, ability to work from home, and loss of income during the pandemic. And socioeconomic position is strongly related to the level of financial assets that are available to cover a potential reduction of household income.

Age. Older people are considerably more vulnerable to COVID-19 related mortality. Only 8% of COVID-19 related deaths occurred among people aged under 65, and, for example, those aged 85 to 89 had a more than eight times higher risk of COVID-19 related mortality, compared with those aged 65 to 69. Older people are also at high risk of social isolation, loneliness and poor mental health. In contrast, young people may suffer the most from the economic impact of COVID-19, with an increased risk of long-term unemployment. However young people with other protected characteristics are particularly vulnerable, with, for example, the impact of school closures likely to be more severe for children in lower socioeconomic positions, employment risks likely to be greater for ethnic minority young people, and risk of loneliness, living in a hostile environment and experiencing poor mental health being a high risk for LGBTQ+ young people.

Other vulnerable groups. Significant inequalities have been identified in relation the prison population, sex workers and homeless people.

VCSE Organisations. VCSE organisations have played a vital role in providing evidence on the experiences of those with protected characteristics, and in documenting the inequalities they are facing. Much of this evidence is not available from other sources. VCSE organisations have also filled service provision gaps for marginalised populations, they play a crucially important role in addressing the needs of their constituents during the coronavirus pandemic. However, many of these organisations are in financially precarious situations, and many have limited capacity to take on these roles.

Recommendations. Based on the evidence reviewed 35 recommendations are offered. These are focused on preventing, or mitigating, inequalities in relation to protected characteristics and socioeconomic position that result from the COVID-19 pandemic and policy responses to it. They are organised around seven target areas that provide a comprehensive mapping of where actions should be developed. The target areas are: reshape the context within which the development and implementation of policy takes place; reduce inequalities in risk of infection, complications and mortality; reduce the amplification of economic and educational inequalities; reduce the risk of domestic abuse and violence; protect the rights of those with marginalised identities; prevent

loneliness and social isolation in vulnerable groups; and reduce the impact on inequalities in mental health.

1. Background

Although the coronavirus pandemic was initially described as a ‘great leveller’, and it was claimed that the COVID-19 virus does not discriminate [1], there is now convincing evidence that there are marked inequalities in COVID-19 related complications and deaths. Alongside this, there are emerging inequalities in the impact of the policies that Government has put in place to manage the pandemic. Indeed, individuals from marginalised, or disadvantaged, groups who are in precarious situations and who already experienced poorer social, economic and health outcomes, are undoubtedly disproportionately affected by the current situation.

This has become most apparent in relation to ethnic inequalities, which were pushed onto the coronavirus agenda by a growing public and media recognition that a large proportion of the NHS and care staff who were dying were of an ethnic minority background. The full extent of these inequalities are detailed in the body of this report, but, given this, it would be something of a surprise if increased risks in relation to COVID-19 were not present for those with other protected characteristics, such as disabled people, lesbian, gay, bisexual, transgender, and queer people (LGBTQ+, the “plus” including those who don’t identify with any such label), women, and people who identify with minority religions. For example, the impact of lockdown may be aggravated for those LGBTQ+ people who already experience isolation, or who might be living in households where parents and other family members are LGBTQ+ phobic, and prejudice is likely to impact on LGBTQ+ people’s access to health services, counselling and other forms of social support [2]. Similar issues are present for disabled people, who also face additional concerns, because of the increased health risk associated with chronic illness and the increased negative social and economic impacts present for those who need to self-isolate [3]. In addition, the Coronavirus Act 2020 reduces the rights of disabled people and carers to social care support, unless any lack leads to a breach of their human rights. Alongside this, although not a protected characteristic, inequalities will also exist in relation to, and will be made worse by, poorer socioeconomic conditions.

Despite these likely dimensions of inequality, there are no existing systematic reviews to examine the extent to which the coronavirus pandemic has impacted on the lives of marginalised populations. In addition to ethnicity, as described above, data do exist to describe the impact of COVID-19 related mortality in relation to age (92% of deaths in England were for people aged 65 or over [4]), gender (among the working age population the death rate among men is close to twice that for women [5]), and, to a limited extent, socioeconomic position (areas in the most deprived quintile have about twice the rate of COVID-19 related mortality, compared with those in the least deprived quintile [6]). However, although information has been emerging since early April, the majority of the data available have been used to only (partially) describe the nature of inequalities in COVID-19 related mortality risk. Little work has been undertaken to investigate what is driving these patterns of inequality and how policy might respond.

Also important is that only limited work has been undertaken to investigate how these inequalities in vulnerability to COVID-19 infection might be amplified by the social and economic consequences of the Government’s pandemic response. It is worth noting that the justification for these lockdown measures and their gradual lifting is that their estimated effect on reducing the impact of the COVID-19 pandemic on the NHS (by protecting its capacity to provide care for people who become seriously ill as a result of a COVID-19 infection) would offset their acknowledged negative economic, social, health and psychological impacts. That is, the negative is on average judged to be worth the estimated direct health benefits. However, the situation facing marginalised groups is far more precarious than the average, meaning that these measures are certainly having a more negative effect on them in both the short and the long term. For example, those in more marginal, or precarious, positions are likely

to: have less opportunity to work from home; have to rely on public transport to get to work; work in more hazardous key worker roles; have one or more long-term condition that they no longer receive routine preventative care for; live in poor quality, privately rented, and insecure accommodation; have lost their jobs, rather than being furloughed; have precarious employment conditions; be self-employed as sole workers, or in a small business; work in catering and other high street industries; face food insecurity; not have access to digital technologies that are vital in the context of social distancing and home schooling; be in less supportive and more abusive living circumstances; be socially isolated; etc. Those in these circumstances are likely to be in increasingly precarious situations as the economic downturn continues and deepens.

1.1 The London context

These issues are particularly acute in London, given the diversity of London's population in relation to ethnicity, migration, gender identity or expression, sexual orientation and socioeconomic position. Indeed, in terms of the risk factors for COVID-19 exposure and mortality, within the UK London has the highest proportion of ethnic minority people [7] and LGBTQ+ people [8], higher levels of overcrowding [9] and substandard housing [10], the highest rates of income and expenditure poverty [11], and high rates of migration and mobility. It is, therefore, not surprising that London had the highest proportion of deaths due to COVID-19 over March and April 2020. Of the 10 local authorities with the highest age-standardised COVID-19 mortality rates, nine were in London [12], with Brent having had the highest overall age-standardised rate with 210.9 deaths per 100,000 population, followed by Newham (196.8 deaths per 100,000 population), and Hackney (182.9 deaths per 100,000 population). Perhaps more surprising is that previous research has suggested that ethnic inequalities in health in London are greater than elsewhere in England and Wales [13], so we may well expect this to be the case for COVID-19 related mortality and infections.

2. Objectives

In this context, the Greater London Authority commissioned a rapid evidence review to examine how the coronavirus was impacting on inequalities in relation to protected characteristics and socioeconomic position. Thus, the objective of the work presented in this report was to conduct a rapid evidence review to document and understand the impact of COVID-19 (both in terms of health and broader impacts on existing social and economic inequalities) on those with protected characteristics, as well as those living in poorer, or more precarious, socioeconomic circumstances, paying particular attention to its effect in London.

This report sets out to map these inequalities in relation to protected characteristics (age; disability; ethnicity, race and religion; gender; and sexual orientation, gender identity and gender expression), and socioeconomic position. It does this by reviewing and synthesising evidence from a number of sources, covering inequalities in risk of infection and mortality, and the impact of measures to manage the pandemic on: access to services; economic position and education; experiences of discrimination and abuse; and loneliness, wellbeing and mental health. It then discusses limits to the evidence and the importance of having an adequate conceptual framing to make sense of the evidence we have access to. Emerging from this evidence review is a clear indication of the importance of VCSE organisations in this period of crisis, both in terms of filling gaps in evidence and in terms of mitigating the amplification of inequalities. Consequently, the report also covers the role of VCSE organisations during the coronavirus pandemic. The report concludes by offering areas for action and a series of recommendations in each of these areas of action.

3. Approach and methods

This work was based on a systematic review, evaluation and integration of existing literature on inequalities in relation to COVID-19 infection, morbidity and mortality, and on the nature of the social and economic inequalities experienced by those with protected characteristics.

Academic and policy literature was drawn from a full range of sources, including: peer reviewed papers; papers currently under review (such as those hosted by medRxiv); publications covering both primary research and policy analysis from ONS, NHS, other Government bodies, local authorities and city regions, policy organisations and think tanks; and, where available, evidence submitted to and reports from Commons Select Committees and other inquiries. The identification of such literature involved a combination of database searches, using appropriate key words, and consultation with and regular review of publications from the organisations listed.

The formalised searches were conducted using Scopus, PubMed, Web of Science and medRxiv, to extract relevant articles published, or preprints¹ registered in the year 2020. The last searched date was 4 July 2020. The following search terms were used:

1. ("COVID 19" OR "Coronavirus" OR "COVID") AND "disab*"
2. ("COVID 19" OR "Coronavirus" OR "COVID") AND ("ethnic*" OR "race" OR "racial")
3. ("COVID 19" OR "Coronavirus" OR "COVID") AND ("gender" OR "sex")
4. ("COVID 19" OR "Coronavirus" OR "COVID") AND ("LGBT" OR "LGBTQ" OR "LGBTQ+" OR "sexuality" OR "gay" OR "lesbian" OR "transsexual" OR "transgender" OR "queer" OR "sexual minority")
5. ("COVID 19" OR "Coronavirus" OR "COVID") AND ("socioeconomic" OR "SES" OR "SEP")
6. ("COVID 19" OR "Coronavirus" OR "COVID") AND "religion"

The articles obtained in this manner were initially screened according to the location of the study population, with research based outside of the UK excluded. Articles were then assessed for relevance according to the study title and abstract. This enabled the identification of false matches (for example, "The race to the top" in a search conducted to extract data on ethnicity and race); models where a protected characteristic was mentioned, but it did not feature in the study results; or studies that appeared either too broad in scope, or out of scope. The full text of the 200 remaining articles was then reviewed to more precisely determine their relevance. Thirty-nine of these articles were included as references in this report. A flow chart showing the total sample size at each point in the search process can be seen in Figure 3.1.

In addition to these academic articles we included research reports from a range of think tanks, public bodies, the NHS and Government departments. It is noteworthy that very little of the research identified through these processes was London based, and that where the research was London based it did not examine how the London context might have shaped outcomes differently from elsewhere in the UK.

Many of these pieces of research report specific types of statistical estimates, that may be unfamiliar to some readers. These include Relative Risk (RR), Odds Ratios (OR), Hazard Ratios, and Standardised Mortality Ratios (SMRs), which can be interpreted as follows:

¹ Preprints are academic papers that are typically awaiting peer-review, which means that some caution needs to be taken when reviewing the evidence that they contain.

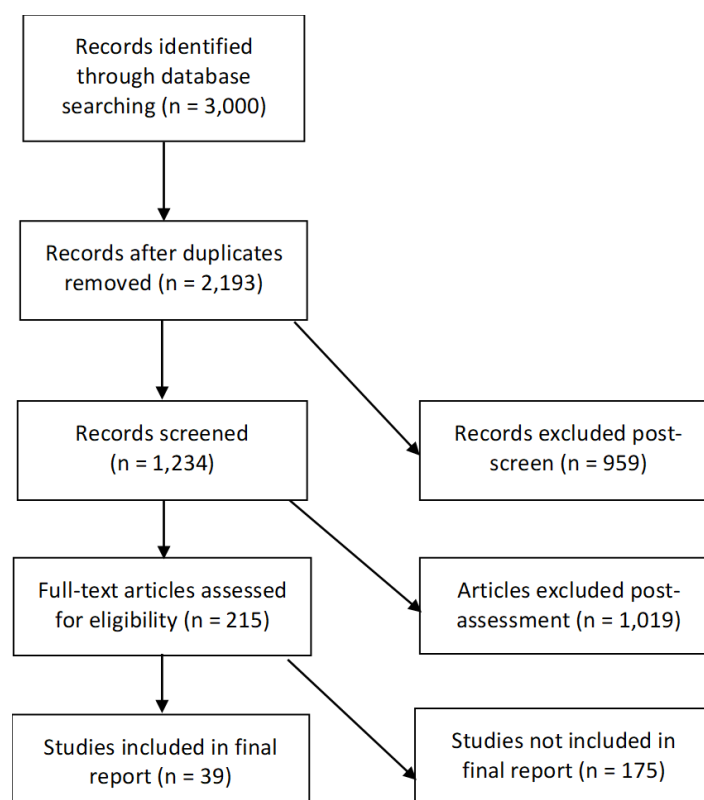
Relative Risk: risk of outcome (e.g. death, infection) in persons with a certain characteristic (e.g. Black ethnicity) / risk of outcome occurring in persons in the reference group (e.g. White ethnicity)

Odds Ratios: odds of outcome in persons with a certain characteristic / odds of outcome occurring in the reference group (the same as RR, but using odds instead of risk)

Hazard Ratios: probability of outcome in persons with a certain characteristic / probability of outcome occurring in the reference group (usually specified within a time frame)

Standardised Mortality Ratio: observed number of deaths in a certain group / expected number of deaths in that group

Figure 3.1: Figure depicting formalised search strategy for literature review



In addition, because of the limited opportunities to draw conclusions from publications or administrative data, and because of the lack of focus on London in that literature, we consulted with voluntary, community and social enterprise (VCSE) organisations in London (civil society organisations, charities, NGOs, voluntary and community organisations) to collate and synthesise evidence that they had produced and published on the health experiences and social and economic precarity faced by those with protected characteristics. We also investigated both the everyday and more strategic challenges faced by VCSE organisations as a result of the coronavirus pandemic and responses to it. Our approach involved engagement with VCSE organisations with a focus on the nine (9) ‘protected equalities domains’ as enshrined in the Equality Act 2010². This involved identifying surveys that had

² Reference to the ‘protected equalities characteristics’ is in relation to the Equalities Act, 2010, where nine (9) ‘equalities characteristics’ were identified where it is unlawful to discriminate on grounds of age, sex, marriage/civil partnership, race, disability, sexual orientation, religion/faith, pregnancy/maternity and gender reassignment.

been undertaken, reviewing reports that had been published, engagement in online stakeholder events and discussion fora, and conducting telephone or zoom interviews. As we describe later in the report, the research (including surveys), consultations, and reports produced by VCSE organisations contributed substantially to, and filled many important gaps in, the evidence available on the experiences of those with protected characteristics. It was therefore an important resource for this review. The full detail of the methods used for the review of evidence produced by VCSE organisations, and a comprehensive account of the findings, can be found in the Ubele Initiative report on this work [14]. Here we draw on that report to present key pieces of evidence from it.

There are some important limitations to the approach adopted that should be noted. First, this was a rapid review of evidence. This meant that the work was completed quickly, including the gathering of evidence, which will have meant that less visible, or less well publicised, pieces of research, or policy analysis, will have been missed. Also missed will be those articles and reports that did not clearly indicate that they contained relevant information on those with protected characteristics, or on socioeconomic differences. However, those articles and reports that identified that they focused on questions of the coronavirus pandemic and protected characteristics, or socioeconomic position, will have been included, so we are confident that we did not miss major pieces of work.

However, second, the timeframe over which this work was conducted has meant that more recent pieces of work, those published after the 4th July 2020, will not have been included. Although, as we note later, there is not an extensive literature, publications are ongoing and it is important for readers to be aware that more recent articles and reports may add to the evidence reported here, including the possibility that gaps in the evidence present here will continue to be filled.

Third, readers will have noticed that terms related to age were not included in the search terms used. This is also largely a consequence of the timeframe over which this work took place. A search that included age-related terms produced many thousands of items, a volume that simply could not be covered in the time available. As a consequence, evidence on age – largely in relation to later life, and children and young people – was extracted from articles that the search identified and from the policy, think tank and ONS reports that we identified as relevant. This means that the coverage of age is more limited in this evidence review than the coverage of other protected characteristics, and that important pieces of academic evidence may have been missed. This has been signalled in the evidence review by having a shorter section on age, found in section 9 of the report, where this relative lack of coverage is compensated for by reporting evidence on age from across the full range of sources that we used.

Fourth, although issues related to marriage and civil partnership, pregnancy and maternity, and gender reassignment, were identified, the literature on these issues was limited and largely incorporated into the sections on gender, and on sexual orientation, gender identity and gender expression.

Finally, a literature review would usually involve each piece of evidence being screened, assessed and analysed by two members of the team. However, time constraints prevented this being done systematically across this work.

4. Disability

4.1. Risk of infection, complications and mortality

There are no sources of data available to directly assess the risk for COVID-19 related mortality of disabled people, in part, because disability is not recorded on death certificates, and, in part, because it is not routinely and systematically recorded on other administrative health data that could be linked to data on mortality, or infection. However, it is likely that disabled people would have a higher risk, as a result of underlying co-morbidities and because of on average being in a poorer socioeconomic position.

To overcome the lack of information, the Office for National Statistics (ONS) undertook an analysis of linked 2011 Census and death registration data [15]. To identify the level of disability a person was experiencing, use was made of the 2011 Census question asking: “Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? - Include problems related to old age”, with the response options “Yes, limited a lot; Yes, limited a little; and No”. ONS suggest that this measure does provide an approximation of both disability and level of disability, even if it is an imperfect measure. However, it is worth considering the possibility that a meaningful proportion of those who say yes to such a question would not actually consider themselves to be disabled. ONS also warns that it is an out-of-date measure, because it is likely that over the nine years since the 2011 Census a meaningful number of people will have moved from the “no” category to one of the “yes” categories, which would lead to an underestimation of any difference between those identified and not identified as being disabled.

The ONS reported age-standardised rates of COVID-19 related mortality by both gender and the level of health limitation (disability), showing that for men with no health limitation the rate was 70.2 per 100,000 people, while for men who report being limited a little the rate was 125.1 (a rate almost 1.8 times higher) and for men who report being limited a lot the rate was 199.7 (a rate 2.8 times higher). Equivalent figures for women were an age-standardised rate of 35.6 for women with no health limitation, 69 for women limited a little (a rate almost twice as high), and 141.1 for women limited a lot (a rate almost four times as high). One important qualification that should be borne in mind when interpreting these statistics is that the imprecision of the measure of disability (having a limiting long standing health problem) means that a large proportion of those with a long term condition meet the criteria, and, of course, almost all cases of COVID-19 related mortality occurred among people with a long term condition. This is particularly important when considering the exceptionally high rates of risk of COVID-19 related mortality for young people who reported having a health related limitation, with those below the age of 65 having negligible risk unless they had a pre-existing health condition.

To account for possible explanations beyond disability that might contribute to this greater risk, the ONS made use of additional 2011 Census data to account for a number of factors, including region of residence, population density and level of deprivation in the area of residence, household composition including multigenerational households, socioeconomic position, highest qualification held, household tenure, and type of occupation. However, these Census data were not available for those living in communal establishments, so the analysis was restricted to only those living in private accommodation. Among this group, with only adjustments for age differences, men whose day-to-day activities were “limited a lot” by their health were 2.5 times more likely to have died than those with no limitation, while those whose daily activities were “limited a little” were 1.8 times more likely to have died, similar figures to those just described for the total population. Adjusting the model for the geographic, demographic, and socioeconomic controls only reduced these risks a little, to 1.9 and 1.6 times higher for men “limited a lot” and “limited a little” respectively. A similar pattern was present

in the analysis for women. Women whose day-to-day activities were “limited a lot” by their health were 3.2 times more likely to die than those with no limitation, while those whose daily activities were “limited a little” were 1.9 times more likely to have died, again figures that are not too dissimilar to those just described for the total population. While, again, adjusting the model for geographic, demographic, and socioeconomic controls only reduced these risks a little, to 2.4 and 1.6 times higher for women “limited a lot” and “limited a little” respectively.

While there are important limitations to the analyses carried out by ONS, because of the reliance on the use of 2011 Census data (so an imperfect and out-of-date measure of disability, and out-of-date measures of possible explanatory factors), the findings nevertheless illustrate shockingly large differences in risk of COVID-19 related mortality, with the risk increasing with an increase in the extent to which health or a disability limits a person’s activities, and with the difference only explained to a small extent by the available measures of explanatory factors. Equally shocking is the possibility, raised by Mencap, that people with a learning disability have a COVID-19 related mortality rate that is high compared with both the care home resident population and the general population [16].

Even on an international scale there is very little evidence to confirm these findings, nor to explain them. An ecological cross-national study revealed that risk of COVID-19 related cases and deaths is related to population level measures of disability-adjusted life years and healthy life expectancy [17]. Disabled people, including those with learning disabilities, are more likely to have comorbidities than those without disabilities [18,19], many of which are associated with an increased risk of COVID-19 mortality (e.g. diabetes and respiratory disease). While children in general may have reduced susceptibility to COVID-19, disabled children may also have comorbidities that raise the possibility of serious complications if they are infected with the virus [20]. Disabled people are also more likely to live in care settings than non-disabled people, especially at older ages. By May 2020, deaths in care homes outweighed deaths in hospitals [21], with as many as 40% of care homes reporting an outbreak by the end of May [22]. And it is estimated that within a residential care home the risk of COVID-19 related deaths is higher for disabled people [23], with a similarly raised risk for disabled people in psychiatric facilities [24].

The increased risk of COVID-19 related mortality experienced by disabled people may also relate to their greater chance of having poorer living conditions. Median pay is consistently lower for disabled people and this is particularly true in London, where there is a disability pay gap of 15.3% compared with 12.2% in the UK as a whole [25]. A report by the Joseph Rowntree Foundation demonstrated that nearly half of those in the UK who live in poverty are either disabled, or live with a disabled person [26]. Indeed, data from 2017/18 showed that 31% of disabled people lived in poverty, compared with 20% of those who are not disabled [26]. Poverty may also be experienced more acutely by disabled people, because of a range of additional living costs they incur [27], and this also impacts on those not living in poverty. For example, an estimate of the material deprivation rate for families not living in income poverty, made in 2016, was 25% for households with a disabled family member, compared with 9% of those with no disabled family members [28]. And, over and above this, estimates of the impact of welfare cuts on the income of disabled people in London show they can expect a £1,910 shortfall in annual household income, compared with a £270 increase in income for those who are not disabled [29].

Altogether, this suggests that the increased risk for disabled people results from their poorer living circumstances and socioeconomic position, associated co-morbidities and vulnerability to ill-health, and increased risks from living in residential facilities. Inclusion London sum up the situation in their report of a survey they conducted on the experiences of disabled people: “Disabled people are experiencing increasing levels of psychological distress, social isolation, a lack of social care support, workplace discrimination, food poverty, and unequal access to health care” [30].

4.2. Access to health, social care and other essential services

“Disabled people feel discriminated against, forgotten, and in some cases abandoned as policy makers have ignored our needs, or at best considered us as an afterthought ... this led to many of us struggling to get bare necessities, losing support, and independence and living in fear of our lives.” [30]

An acute illustration of the situation summarised by this quote is that despite the estimated increased risk of people with learning disabilities to die with COVID-19, until the 5th June, Government advice stated that care home residents with a learning disability were not automatically eligible for COVID-19 tests [31], and requests for tests were reported to have been blocked [32].

More generally, the coronavirus pandemic has been described as creating “collateral damage” to disabled people by limiting access to health services, such as rehabilitation, thereby potentially increasing functional limitations for those with chronic conditions [33]. One survey, covering Italy, Belgium and the UK, reported that outpatient rehabilitation had stopped for 87% of respondents [34]. Indeed, disabled people were significantly more likely than non-disabled people to be concerned about their access to healthcare and treatment for non-coronavirus-related issues (40.6% compared with 21.2%). They were also significantly more likely to be concerned about their health (20.2% compared with 7.3%) [34].

It is well established that the public health response to the pandemic has created barriers generally in access to acute care, non-acute care and social care [35], and there is evidence that this has been particularly disruptive to disabled people [36]. The likely vulnerability of disabled people in this context is reflected in Carers UK’s estimate that 4.5 million people became unpaid carers in the first weeks of lockdown [37]. While for some disabled people who care for friends, or family members, the lockdown restrictions and requirements to shield may have reduced their ability to provide support [38]. And others, as illustrated in a report by Inclusion London, may have cancelled care due to fear of catching COVID-19 from carers, because they had not been provided with adequate Personal Protective Equipment (PPE) [30]. For example, one person said:

“We have had to cancel the social care that we receive (funded by Direct Payments) because of the concerns our carers would bring the infection into the house, and would be inadequately provided with PPE. We were unable to access the government scheme to provide food parcels, in spite of my condition causing me to be immunosuppressed and therefore needing to be shielded. In addition, our council recently cut the care package due to financial constraints, and therefore all access to help with housework”.

In the same report, parents of disabled children reported how access to many services had been stopped causing a severe impact on their mental health and that of other carers of their children [30]:

“It was as though the moment schools closed there was a notion that I would be able to deliver to my child mental health support, counselling, therapies, education, social care. No responses when contacting local authority.”

While a young disabled person said [30]:

“My parents are having to care for me as my carer is super shielded. So I have no care. My parents can’t provide the care I need. I don’t have the information I need for this scenario. I’ve

been provided very little information about what to do and where to get help. I feel very isolated and my mental health is really suffering. I don't know how to cope. I'm really scared for my health. If I get the virus I don't know how we would cope as who would care for me."

In terms of access to services beyond health and social care, it has been highlighted that the Government definition of vulnerable, which gives priority for certain forms of support, has not included all people with additional needs. An example of the impact of this was where supermarket deliveries were limited to the officially vulnerable, excluding some disabled people who would struggle to shop independently while maintaining social distancing, including wheelchair users and people with visual impairments [39]. To illustrate this, it has been reported that visually-impaired people, who often rely on touch to navigate their surroundings, have cancelled out-patient appointments with oncologists because of their perceived risk of going outside, where surfaces could be contaminated with the virus [40]. In addition, an ONS survey found that people with hearing impairments were the least likely to have left their homes, or to have visited a green space, in the previous seven days [41], possibly due to PPE causing discomfort when worn with hearing devices and inability to lip read others, due to them wearing PPE [42]. And a survey of disabled people commissioned by Scope showed that 38% of those surveyed had been unable to book supermarket delivery slots in the previous three weeks and that 36% of shoppers said long queues were aggravating their conditions or impairments [43]. As one person reported [44]:

"The rules for getting on the extremely vulnerable list are so strict, my doctors want me on it but cannot get me on it. I use a home nebulizer and home suction machine, as my asthma is extremely bad, but nebulizer is not mentioned for asthma only COPD. PPE is impossible to get hold of and when you can it's very expensive. Food delivery spots are hard to get and then they don't have what you need. There is not enough advice or help for disabled people or family carers and none provided in a clear format for those who struggle to read."

More generally, a survey conducted by Inclusion London revealed that over 60% of those responding struggled to access food, medicine and necessities, because of poorly organised shops and online facilities [30].

4.3. Employment and education

In the context of rising levels of unemployment, it seems likely that employment inequalities in relation to disability will increase. However, the movement to home working and home education has potentially brought some benefits. In those cases where workplaces and educational establishments have put appropriate structures in place, this has reduced the difficulty of accessing appropriate travel to place of work and education, and accessing appropriate resources in office and education spaces. However, these improvements have been received with some disdain by disability activists who had been told previously that this way of engaging in work or accessing education were not possible, or too difficult to implement. Charli, a 19 year old IWill Ambassador, student, and member of the Scout's community, illustrates both the benefits of these changes, as well as the frustration that they had not been previously offered:

"COVID-19 is making an impact across all of our daily lives – but for me, as a disabled and chronically ill young person, some of these challenges are already familiar. As an activist, I am fighting for better communication and support for disabled people, both during this crisis and in the future. Here are the lessons I feel we can all learn from the COVID-19 crisis."

Increased accessibility is a possibility, and it should be here to stay. For many disabled people, traditional education and work-places are not spaces we fit. When asking for accommodations like working from home, it is seen as an inconvenience, and we are told they aren't possible. Yet when COVID-19 began, it took only days for companies and universities to move online and to adapt imaginatively to using new digital tools. While welcome, I can't say I didn't feel frustrated that this was suddenly possible.

I don't think these tools should necessarily replace standard ways of working, but there is no reason for them to be abandoned completely after the crisis. For example, my lecturers have been uploading the written transcripts they would use in-person. So why isn't this always uploaded to support those who struggle with the normal recordings? Many pupils find lectures challenging due to concentration and sensory issues or being hard of hearing.

Similarly, for those of us dealing with chronic pain and fatigue, working from home can be a key accommodation. Having to drag our aching and exhausted bodies into an office or to two hours long lectures daily is no easy feat. Right now, being able to take our time and tailor our days to fit our bodies feels like a luxury – but it shouldn't be. The current accommodations could enable so many more to work or study and make us feel truly integrated into society. Having a meeting over Skype or Zoom instead of travelling for hours can mean I don't deal with the payback my body gives me for days afterwards, and that little break can mean the world. Telephone medical consultations can also be a relief for many.” [45]

However, while for many children a move to online teaching may be a workable educational solution, such methods may not be suitable for disabled children who require more specialist care [46]. One participant to the Inclusion London survey said: “My child with special needs has been unable to attend school for the duration of the lock down, causing huge amount of anxiety and distress within the household. He has also had all external support and care removed” [30].

4.4. Risk of discrimination

Evidence provided to the Women and Equalities committee has criticised the Government for not using inclusive approaches to COVID-19 related communications. Examples of this have been the Government not providing a sign language interpreter during their daily briefings, and not providing large print resources for older people with acquired sight loss [47]. A related set of issues are present for those with learning disabilities, for whom there may be difficulties communicating appropriate precautions and protocols around COVID-19 [48].

A more fundamental threat to the rights of disabled people have been the options included in the Coronavirus Act 2020 that allow for a reduction in the protections afforded by the Care Act 2014 and the Mental Health Act 1983. A Health Foundation report into adult social care during COVID-19 claimed that the social care system prior to COVID-19 was “underfunded, understaffed, undervalued and at risk of collapse”, and that these longstanding policy failures have been exacerbated by the pandemic [49]. As part of the Coronavirus Act 2020, “easements” were made to the Care Act 2014, meaning that local authorities could reduce their usual duties to assess and arrange services to meet the needs of disabled adults and their carers. This was met with considerable concern by disabled campaigners [50,51], and early in the pandemic several councils triggered easements [52], although at the most recent recording, on the 3rd July 2020, the Care Quality Commission reports that no local authority in England was still using easements [53]. Despite this limited uptake, in a survey of directors of adult social services, only 4% thought their allocated budget would be sufficient to meet statutory duties, a reduction from 35% in 2019/20 [54], leaving the possibility that this option might still be

used. And, as described above, there is evidence that disabled people are not receiving the same level of care as they did before the coronavirus pandemic.

Similarly, the Coronavirus Act 2020 significantly reduced the protections provided for patients who are detained under the Mental Health Act 1983, enabling a patient to be detained on the judgment of only one approved doctor, extending the length of time a person can be detained in emergency situations, and reducing opportunities for the detention and the treatment received to be examined by a full Mental Health Tribunal. This led to concerns that this may result in an increase of people with learning disabilities being detained under the Mental Health Act [19], although this option has not to date been taken up.

4.5. Loneliness, wellbeing and mental health

Lockdown has also impacted on the mental health of disabled people. Disabled adults were more likely to report spending too much time alone or feeling lonely compared with non-disabled adults; they were also more likely to feel like a burden [41]. Nearly two-thirds of disabled adults said COVID-19 related concerns affecting their wellbeing [44]. In the Inclusion London survey, over 35% of respondents identified increasing levels of psychological distress as a result of social isolation, loss of control and agency, and a lack of access to mental health support services in the community, as well as fear around the immediate impact of the coronavirus pandemic [30]. Indeed, their concerns included fears of dying, being denied health care, and not having enough money to put food on the table or heat the home.

Although lockdown increased anxiety ratings among disabled people on average, anxiety was higher among those with a mental health or socio-behavioural impairment, and lower among those with dexterity, mobility or stamina impairments [41]. In addition, changes in routine and structure could be particularly detrimental to the well-being of people with learning disabilities, and lead to challenging behaviour and mental health problems [19]. In some residential services, visits from anyone not providing essential care have been indefinitely postponed, creating anxiety for some with learning disabilities as to when they will next see their family [55].

There are also indications that the pandemic has been particularly challenging for families of children with autistic spectrum conditions, due to the cessation of services that removes valuable time with therapists or in dedicated institutions [56–58]. Disruption to routines may be particularly distressing for some members of this group [59], potentially leading to an increase in challenging behaviours [60]. In addition, the mental health impacts of COVID-19 on disabled children may be particularly severe as a result of the closure of specialist educational centres and services [61].

In this context, it appears that disabled people have faced a lack of access to mental health support services and feel abandoned, with it taking days and weeks to get a response from the GP or local authority [30].

5. Ethnicity, Race and Religion

5.1. Risk of infection, complications and mortality

5.1.1. Pattern of inequalities

Ethnic inequalities in COVID-19 related deaths is perhaps the area of inequality that has received most attention during the coronavirus pandemic. An initial focus on these inequalities appears to have been forced by growing public and media recognition that a large proportion of the NHS and care staff who were dying were not white. These concerns led to policy and academic research that clearly showed an increased risk of COVID-19 related mortality for ethnic minority groups. The earliest evidence, a report by The Intensive Care National Audit and Research Centre published in April 2020, showed that around 35% of COVID-19 related admissions to intensive care were ethnic minority people and ethnic minority admissions were slightly more likely to die in critical care (for example, 48.4% of White patients died in critical care compared with 55.3% of ethnic minority patients) [62]. Given that non-white ethnic minority people made up 14% of the population in England and Wales at the 2011 Census, these numbers suggest a marked inequality. This impression was reinforced by analysis of data released by the NHS, which suggested meaningful increases in death rates for ethnic minority people after taking into account differences in age and gender structures, and place of residence [63, 64]. In early May, the ONS then published unique analyses using linked Census 2011 and death registration data [65]. This allowed for the modelling of risk of COVID-19 related mortality by ethnicity and gender, as recorded at the census, and to carry out adjustments for a range of demographic, geographic and socioeconomic factors also recorded at the Census.

Figure 5,1 shows the odds of COVID-19 related mortality for Bangladeshi/Pakistani, Black, Chinese, Indian, Mixed and Other ethnic minority groups, compared with the odds of COVID-19 related mortality of the White British group (represented by the bolded line at the value 1). The documented age adjusted ethnic inequalities in risk of COVID-19 related mortality are large, and, with the exception of Chinese people, broadly consistent for men and women. For example, Bangladeshi/Pakistani people had a more than three times higher risk of COVID-19 related mortality compared with White British people, Black people a more than four times higher risk, and Indian people and those in the Other group a more than two times higher risk. Risks were also statistically significantly higher for Mixed people and for Chinese men. The only group without a higher risk of COVID-19 related mortality in these analyses were Chinese women.

Additional analyses presented in the ONS report revealed that a substantial part of the increased risk faced by ethnic minority groups may have resulted in differences in where people lived, their socioeconomic position and pre-existing health (all as measured at the 2011 Census) [65]. This is illustrated in Figure 5.2, which compares the odds of COVID-19 related mortality for Black, Indian, Bangladeshi/Pakistani, and Other ethnic minority groups, compared with the odds of COVID-19 related mortality of the White British group (again represented by the bolded line at value 1). The figure shows that the odds of COVID-19 related mortality are higher for all ethnic minority groups, when compared with the odds of the White British group, even when adjusting for age (green bar). For each of four broad ethnic minority groups, the odds of COVID-19 related mortality reduce when adjusting for geographical factors (blue compared with the green bars), and reduce further when adjusting for socioeconomic and health factors (yellow compared with the green bars). After adjustment for all of these factors, the model showed that the risk of death involving COVID-19 compared with White men and women was 1.9 times greater for Black men and women, 1.8 times greater for Bangladeshi and Pakistani men, 1.6 times greater for Bangladeshi and Pakistani women, 1.3 times greater for Indian men, and 1.3 times greater for men in the 'Other' ethnic minority group [65].

Figure 5.1: Ethnic differences in COVID-19 related mortality, age adjusted odds ratio compared with the White group (Adapted from ONS analysis [65])

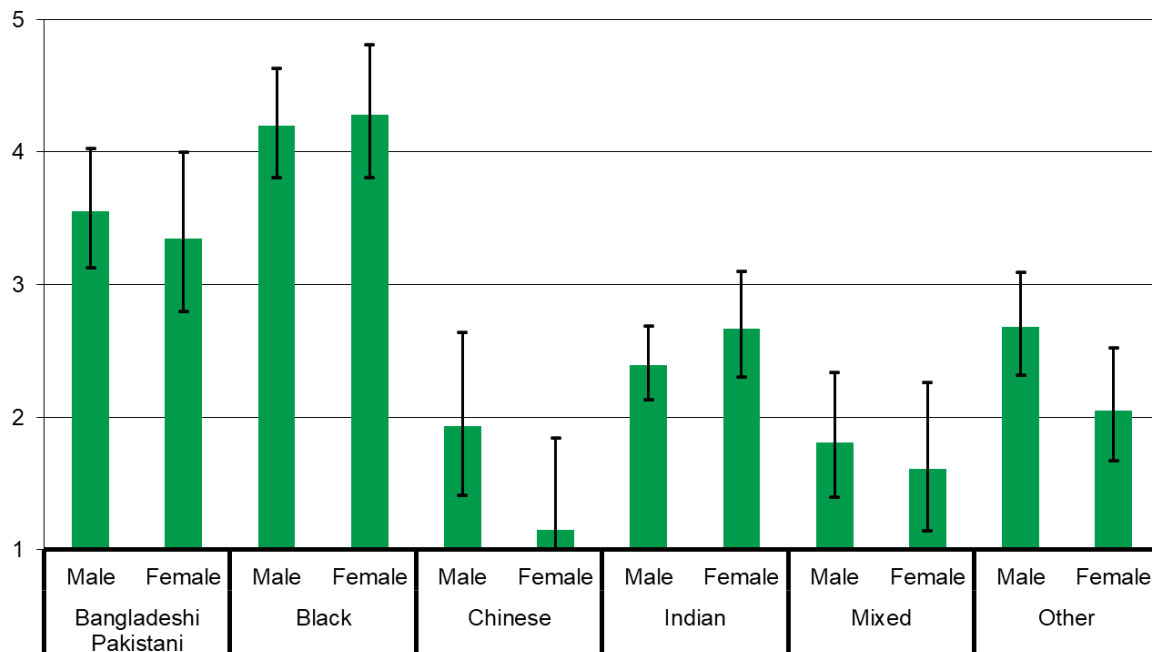
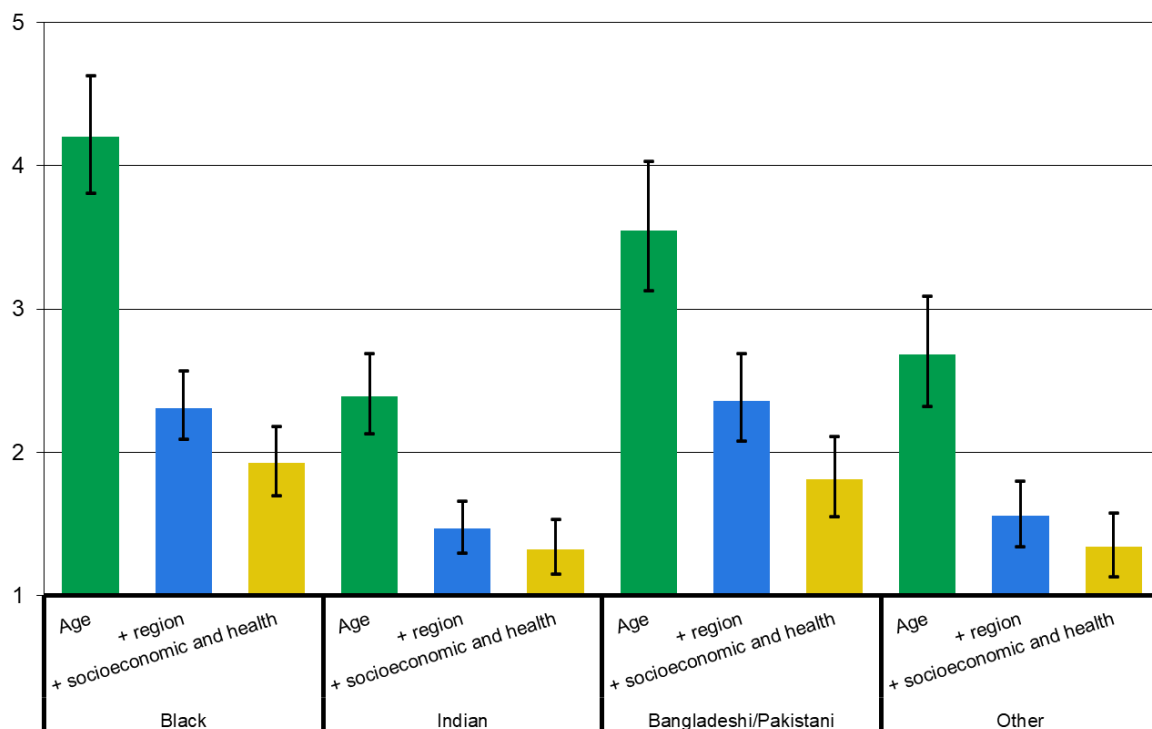


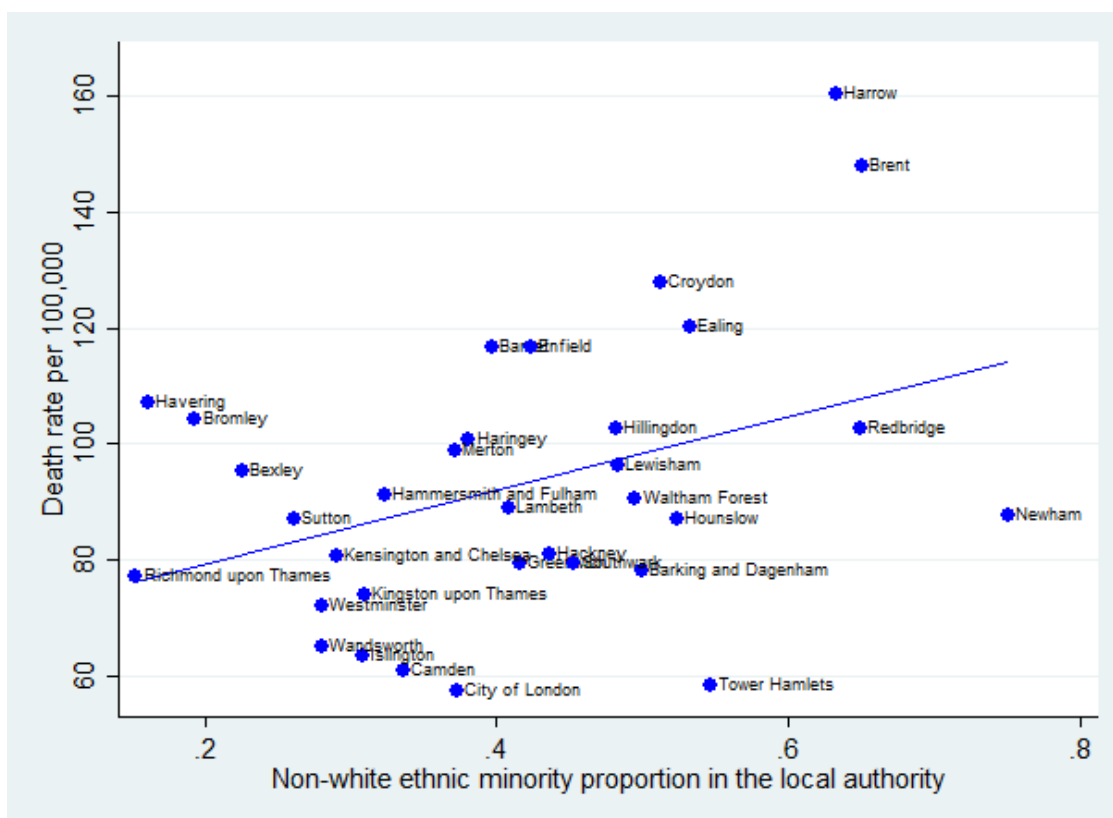
Figure 5.2: Ethnic differences in COVID-19 related mortality for men, impact of geography, socioeconomic position and health, age adjusted odds ratio compared with the White group (Adapted from ONS analysis [65])



Further evidence using a wide range of data sources has continued to demonstrate the presence of large ethnic inequalities in COVID-19 risk, inequalities that are present for almost all ethnic minority groups studied (the only exception being Chinese women), including White minority groups.

Confirming these findings, an ecological analysis of mortality rates showed that the risk of COVID-19 related mortality in a local authority was strongly related to the proportion of the population who are from an ethnic minority group [66]. This is summarised for those local authorities in Greater London in Figure 5.3, which shows the relationship between mortality rates up to July 31st (the vertical axis) and the proportion of the population in the local authority that is ethnic minority (the horizontal axis). Although the size of the ethnic minority population does not explain all of the variation across local authorities, the line in the graph shows that there is a clear relationship, with an increasing proportion of non-white ethnic minority people in a local authority related to an increase in mortality rates. The model predicts a COVID-19 related mortality increase of 6.4 per hundred thousand for a 10% rise in the proportion of the non-white population in the borough, while, after controlling for other factors related to area deprivation, level of pollution, population density and proportion of the population who are older, this number rises to 11.4 per hundred thousand for a 10% rise in the proportion of the non-white population. Importantly, these and other analyses suggest that while there may be some variation in the size of the risk across specific ethnic minority groups, the risk is higher for an increasing proportion of the population for each ethnic minority group. That is, the increased risk of COVID-19 related mortality is present across all ethnic minority groups and is not confined to discrete groups, even if the size of the inequality varies across them. However, it should be noted that this is an ecological analysis, so while it identifies variation in mortality risk across areas, and how this is associated with characteristics of an areas, it does not identify who within an area is at greater risk, and gives no insight on causal processes. What such analyses do is indicate lines for future inquiry.

Figure 5.3: COVID-19 related mortality and proportion of ethnic minority people in London boroughs, deaths up to 31st July



A summary of findings from papers and reports presenting statistical analyses reporting on ethnicity and COVID-19 is included in Table 1. Due to differences in how results were reported, results may be combined for two or more ethnic groups. Also, studies are characterised according to which element of risk they are focused on (the 'Type' column). Here the scheme proposed by the Race Equality Foundation is used, which argues for the need to distinguish between the different available measures of COVID-19 risk that have appeared in research [67]. In particular, it distinguishes between statistical analyses that focus on:

1. Infection Rate (IR): Risk of infection among the whole population;
2. Infection Fatality Rate (IFR): Risk of dying from COVID-19 among those who are infected;
3. Population Fatality Rate (PFR): Risk of dying from COVID-19 among the whole population (so 1. and 2. Combined).

The findings summarised in Table 1 are reasonably consistent across studies, despite variations in the type of statistical model used and the range of explanatory variables controlled for. They show the presence of an increased risk of COVID-19 related mortality for all ethnic minority groups, except the Chinese group.

Table 1: Summary of published results on risk of COVID-19 related mortality for selected Asian and Black ethnic groups, compared with White ethnic groups³

Reference	Adjustments	Type	Bangladeshi	Pakistani	Indian	Chinese	African	Caribbean
National patient data:								
ONS [65] (to 10 April; N=population)	Age, sex, geography, SES	PFR (Odds Ratios)	F: 1.61 (1.31-1.97) (Bangladeshi & Pakistani)		F: 1.43 (1.20-1.71)	F: 0.75 (0.47-1.22)	F: 1.89 (1.63-2.20) (Black)	
			M: 1.81 (1.55-2.11) (Bangladeshi & Pakistani)		M: 1.32 (1.15-1.53)	M: 1.18 (0.85-1.63)	M: 1.93 (1.70-2.18) (Black)	
Aldridge et al. ⁴ [63] (to 21 April; N=population)	Age, region	PFR (SMRs)	2.41 (1.98-2.91)	3.29 (2.96-3.64)	1.70 (1.56-1.85)	1.14 (0.87-1.45)	3.24 (2.90-3.62)	2.21 (2.02-2.41)
Platt & Warwick ⁵ [64] (to 21 April; N=population)	Age, sex, geography	PFR (SMRs)	2.0	2.9	1.6	-	3.7	1.8
OpenSAFELY [68] (to 6 May; N=17,278,392) (Extended Data Table 1)	Age, sex, deprivation, health, lifestyle	PFR (Hazard Ratios)	1.84 (1.44-2.08)	1.24 (1.05-1.46)	1.40 (1.23-1.59)	1.22 (0.81-1.84)	1.78 (1.42-2.23)	1.28 (1.07-1.53)
PHE ⁶ [69] (to 13 May; N=population) (Table A1, Appendices)	Age, sex, geography, deprivation	IFR (Hazard Ratios)	2.02 (1.74-2.35)	1.44 (1.31-1.58)	1.22 (1.13-1.32)	1.28 (1.04-1.58)	1.06 (0.96-1.18)	1.10 (1.02-1.19)
ONS [70] (to 17 May; N=population)	Age, sex, geography, SES	PFR (Odds ratios)	F: 1.08 (0.94-1.25) (Bangladeshi & Pakistani)		F: 1.59 (1.46-1.73)	F: 0.97 (0.73-1.27)	F: 1.41 (1.29-1.55) (Black)	
			M: 1.51 (1.37-1.67) (Bangladeshi & Pakistani)		M: 1.14 (1.02-1.28)	M: 1.23 (0.99-1.53)	M: 2.03 (1.89-2.19) (Black)	
UK Biobank studies:								

³ All results reported against White British group as reference (Or White group for ONS, Lassale, Raisi-Estrabragh et al., Apea et al.)

⁴ Reference: White British: 0.88 (95% CI 0.86-0.89)

⁵ Figures for Bangladeshi and Indian groups estimated from chart as statistic not provided in text

⁶ Original PHE report contained PFRs but were reported simply as age-standardised mortality ratios

Reference	Adjustments	Type	Bangladeshi	Pakistani	Indian	Chinese	African	Caribbean
Patel et al. [71] (to 14 April; N=418,794) Outcome: Hospitalisations	Age, sex, SES, health, geog., lifestyle	IR (Relative Risk)	1.75 (1.08-2.85) (Asian)				2.38 (1.52-3.74) (Black)	
Prats-Uribe et al. ⁷ [72] (to 14 April; N=415,582)	Age, sex, depr., health, lifestyle	IR (Rel. Risk)	2.04 (1.36-3.07) (Asian)			3.00 (1.11-8.06)	3.30 (2.39-4.55) (Black)	
Lassale et al. [73] (to 26 April; N=340,966) Outcome: Hospitalisations	Age, sex, SES, health, lifestyle	IR (Rel. Risk)	1.43 (0.91-2.26) (Asian)				2.66 (1.82-3.91) (Black)	
Niedzweidz et al. [74] (to 3 May; N=392,116) (Supp. Info Table S7)	Age, sex, SES, health, lifestyle	IR (Rel. Risk)	-	1.84 (0.90-3.76)	1.52 (0.92-2.52)	1.19 (0.37-3.80)	1.53 (0.87-2.69)	2.18 (1.43-3.32)
Raisi-Estabragh et al. [75] (to 18 May; N=4,510)	Age, sex, health, deprivation	IR (Odds Ratios)	Whole sample: 1.78 (1.43-2.20) "BAME ethnicity": F: 1.55 (1.15-2.09) / M: 2.07 (1.50-2.84)					
Smaller N, London-specific studies:								
Hull et al. ⁷ [76] (to 30 April; N=1,257,130) (4 East London NHS CCGs)	Age, sex, deprivation, health	IR (Odds Ratios)	2.00 (1.86-2.10) ("South Asian")			-	1.53 (1.43-1.63) (Black)	
Apea et al. ⁷ [77] (to 13 May; N=1,737) (5 East London hospitals)	Age, sex, deprivation, health, lifestyle	IFR (Odds Ratios)	1.48 (1.09-2.01) ("Asian or Asian British")			1.32 (0.96-1.84) ("Black or Black British")		

Following the analysis of ethnic inequalities in risk of COVID-19 related mortality, ONS also conducted an analysis of differences in risk by religious affiliation. To do this, data from the 2011 Census on religious group, along with other demographic factors, was linked to death registration data [78]. Findings showed that Muslim, Jewish, Hindu and Sikh people were at greater risk of COVID-19 related mortality compared with Christian people. Once the data were age-standardised, the highest COVID-19 related mortality rate was found for those in the Muslim group, with a rate for men of 198.9 deaths per 100,000, and a rate for women of 98.2 deaths per 100,000, rates that were 2.5 and 1.9 times higher than those for Christian men and women, respectively. Those in the Jewish group had the second highest mortality rates, with age-standardised rates that were almost as high as those in the Muslim group, with a rate for men of 187.9 per 100,000, and for women of 94.3 per 100,000. Hindu and Sikh men and women also showed higher mortality rates than other groups. While those in the "no religion" group had the lowest rate of COVID-19 related mortality, with men having a rate of 80.7 deaths per 100,000, and women having a rate of 47.9 deaths per 100,000. Adjustments for 2011 Census measures of geographic, demographic, socio-economic factors and occupational exposure and self-assessed health, reduced these differences substantially, suggesting that such underlying inequalities were important factors, but differences remained for many groups.

⁷ Preprint study

5.1.2. Explanations for ethnic, race and religious inequalities in COVID-19 infection and mortality

Ethnic health inequalities in the UK are well-known, having been documented in numerous research papers and government reports [79–82]. These inequalities extend to both physical [83] and mental health [84,85]. People from certain ethnic minority groups are more likely to experience long-term health issues [86], and it is estimated that Black Caribbean, Pakistani, and Bangladeshi people have six to nine fewer years of disability-free life expectancy compared with White British people [87], suggesting that biological ageing is occurring at a faster rate among ethnic minority people. Higher levels of mortality for people from ethnic minority groups have been seen in previous pandemics [88], albeit not to the same magnitude as currently observed for COVID-19 related mortality.

There has been much discussion of what might be driving ethnic inequalities in COVID-19 infections and outcomes. Perhaps not surprisingly, central to this has been the likelihood that the increased risk results from the underlying social and economic inequalities that are faced by ethnic minority people, including: poorly paid and insecure employment; over-crowded poor quality housing; and living in deprived neighbourhoods with high rates of concentrated poverty [89]. Ethnic minority people are also more likely to both live in urban areas where spread of the virus occurs more readily, and to be employed in sectors that increase their risk of exposure to the COVID-19 virus, such as transport and delivery, security, cleaning, as health care assistants, in social care, and in nursing and medicine [5]. In London, ethnic minority people are more likely to work in occupations characterised by high proximity to other people. This is particularly the case for Black (39%) and Pakistani/Bangladeshi workers, at 39% and 36% respectively, compared with 22% of White workers in London [90]. Ethnic differences in the proportion of London residents in key worker occupations are of similar order, with 38% of those in the Black and Indian groups holding such a role, compared with 26% of those in the White group [90]. So, consequently, ethnic minority people are more at risk of being infected with the virus. In addition, ethnic minority people are more likely to have underlying health conditions that have been linked to increased risk of COVID-19 complications and mortality, such as diabetes, high blood pressure, and coronary heart disease. However, these health conditions are patterned by the social and economic inequalities faced by ethnic minority people [82]. As a result, the increased risks associated with COVID-19 are a core component of wider ethnic inequalities in health and the negative consequences of a COVID-19 infection are amplified by pre-existing ethnic inequalities in health, both of which are driven by social and economic inequalities. Crucial, however is that the patterning of these social and economic inequalities are underpinned by longstanding and enduring structural and institutional racism and racial discrimination [66].

In the sections below we describe the studies that have provided evidence for these mechanisms, which highlight the longstanding social and economic inequalities experienced by ethnic minority people, which have led to the stark COVID-19 inequalities in infection and mortality.

5.1.2.1. *Increased risk of exposure to COVID-19*

A study from April reported that over two-thirds of the known deaths of UK health and social care workers occurred among people from ethnic minority groups [91]. Over twenty percent of all NHS staff are from a non-White ethnic background, with London having an even higher proportion of NHS trust staff with ethnic minority backgrounds, at 45% [92], while overall 44% of doctors are from ethnic minority backgrounds [93]. However, there are documented inequalities within these occupations, with NHS ethnic minority staff significantly under-represented in the highest pay bands and over-represented in the support pay bands [92]. The nature of support work means that it cannot be done remotely, suggesting this group may be at higher exposure risk, although COVID-19 deaths among ethnic minority groups have been documented across a range of healthcare occupations [94,95].

A survey of NHS doctors found that ethnic minority doctors felt more pressured and less protected than white colleagues [96], while an earlier survey reported that just 4 out of 10 doctors from ethnic minority groups felt they had adequate PPE compared with 7 out of 10 of those from white groups [97]. Levels of health concern were also much higher for ethnic minority doctors, for example in a survey of 1,582 members of the Royal College of Physicians, 76% of ethnic minority respondents were concerned, or very concerned, about their health, compared with 48% overall [98]. Another online survey of hospital doctors, where 94% of the sample were from an ethnic minority group, found that insufficient access to personal and protective equipment (PPE) was reported to be the main factor in having a diagnosis or suspected diagnosis of COVID-19 [99]. In the same survey, access to PPE was significantly lower for Muslim NHS workers compared with others; furthermore, Muslim doctors were more likely to be reprimanded for wearing, or asking for PPE [99]. While, a staff survey conducted by the NHS reported that ethnic minority staff members, particularly nurses, reported not feeling confident enough to request PPE, or COVID-19 testing [94]. The same survey identified that certain forms of PPE may not be suitable for those who wear a hijab, or have a beard. And, despite the mandate for risk assessments to be conducted for all ethnic minority NHS staff, in July many NHS trusts still had not done this [100].

Research conducted by ONS examined the relationship between occupation and risk of COVID-19 related mortality for those who were employed. This shows increased risk of COVID-19 mortality for occupations such as nursing auxiliaries and assistants, taxi and cab drivers and chauffeurs, and security guards and related occupations, though not for doctors or nurses [5]. A separate study (reported in an preprint paper) found that medical support workers and social care workers were particularly at risk [101]. ONS analysis showed that of the 17 occupations that were identified as having higher risk of COVID-19 mortality for men, 11 of them had significantly higher levels of workers from ethnic minority backgrounds, while among women 2 of the 4 occupations identified as having higher risk of COVID-19 mortality had higher levels of ethnic minority workers [5]. In more detail, the transport and security sectors had disproportionately high numbers of male workers from the Bangladeshi, Black and Other groups; for example, men in the Bangladeshi group comprised 33% of taxi and cab drivers and chauffeurs, despite making up 3.1% of working age men. The Black group also had higher numbers of men working as cleaners or domestic workers, and in the health care sector. The Indian and Bangladeshi group had proportionally higher numbers of men working as shopkeepers and proprietors (13.2% and 11.9% respectively, despite making up of 3.4% and 3.1% of the working-age population). Among women, the Black group had higher representation than others in health care, comprising 9.1% of nurses and 13.2% of care workers and home carers, compared with their proportion of 3.9% of the working age population. Bangladeshi women had roughly double the expected representation in the “Sales and retail assistants” and “National government administrative occupations” sectors [5].

Financial worries and insecure employment, which is more common for ethnic minority people [102–104], are thought to have been behind some of the increased exposure to COVID-19 infection, and consequently avoidable infections and deaths. For example, some workers showing signs of COVID-19 were unable to self-isolate due to the precarity of their work situation [105] [106] [107]. Ethnic minority people living in London, from all groups, have a higher risk of such precarious work situations, with, for example, 16% of Black workers experiencing insecure work, compared with 6% of White workers [90]. Additionally, Ethnic minority people living in London are less likely to have financial savings of at least £1,500; just 33% of Black people in London have this amount saved, compared with 69% of White British people in London [108]. Ethnic minority people in London are also more likely to be in arrears for their household bills, or be experiencing a heavy burden of financial debt [109]. In terms of increased workplace exposure, as described above, figures from London based on 2019 data show that, on average, the type of work done by people in ethnic minority groups has higher levels of

proximity to others and, consequently, the risk of exposure to disease, compared with the White British group [90].

In addition, a recent report published by the ONS using data from the 2019 Annual Population Survey showed that rates of home-working were lowest for the Pakistani and Bangladeshi ethnic groups pre-pandemic, suggesting that they were less likely to be able to work from home during the pandemic [110]. People in the White Other, Pakistani and Bangladeshi groups are more likely to be self-employed than the White British population [111] and, given the delay in implementing the Self-Employment Income Support Scheme relative to the support for employed workers, self-employed workers may have felt compelled to keep working as the pandemic progressed. A preprint paper, using data from a survey conducted in March 2020, showed that while willingness to self-isolate was high across all ethnic groups, ability to self-isolate was lower in ethnic minority groups [112]. The exact cause of this was not established in the paper; however, ability to work from home and self-isolate if needed was lower for those from more disadvantaged backgrounds, hinting at structural barriers being a driving factor. Also, it was noted that people from ethnic minority groups are more likely to have to rely on public transportation to travel to their place of work [94,95,113].

5.1.2.2. *Area of residence and housing*

A preprint study found that COVID-19 mortality was linked to the ethnic composition of the area: for every 1% rise in the ethnic minority population, deaths increased by 5.10 (3.99 to 6.21) per million [66]. Adjusting for population density, area deprivation and pollution slightly reduced this effect, suggesting this association is partly due to ethnic minority people living in more densely populated, more deprived and more polluted areas. Another widely-suggested factor for the elevated COVID-19 risk among ethnic minority groups is household overcrowding [64,114], which is more common for every ethnic minority group, compared with the White British group [115]. A report of a survey conducted by the Anti-Tribalism Movement [116], a Somali community organisation, which covered 27 Somali-led organisations, 12 Somali community leaders and academics, 3 Somali professional associations, 9 Somali businesses, 4 Somali media channels, and dozens of British Somali individuals, noted that many generations of families live together in often cramped households. One participant noted that this alongside *“Somalis’ nomadic culture and travel between European countries may have also contributed to the virus’ spread among the community before lockdowns were imposed. My own London home, for example, has often been a transit point for travelling friends and relatives.”*

Indeed, a study looking at COVID-19 infection and household size found that each additional household member was associated with an increased infection risk [75]. There was also the concern that among intergenerational households (which are more common in Bangladeshi, Indian and Chinese households [117,118]), more socially-active young people may spread the disease to older people in their household. However, there is limited evidence to support this hypothesis, and in the many studies that have included household size as a predictor for ethnic differences in risk, the higher risk for ethnic minority people did not change meaningfully when household size was adjusted for [65] [75] [70] [74] [73].

5.1.2.3. *Pre-existent health conditions*

As documented earlier, people from ethnic minority groups have higher levels of a number of chronic health conditions [83]. Specific health issues that are disproportionately prevalent among certain ethnic minority groups may exacerbate the severity of COVID-19 infection, such as lower respiratory tract infection [119], diabetes [120] and vitamin D deficiency [121]. It is important to recognise that these health conditions are patterned by the social and economic inequalities faced by ethnic minority people [82]. However, research from the OpenSAFELY collaborative, using linked primary care and

death registration data, showed that ethnic inequality in COVID-19 mortality could not be explained by differing levels of comorbid conditions and that, in fact, comorbidities had a relatively small impact on inequality compared with socioeconomic factors [68]. While work using the UK Biobank data found that ethnic differences in levels of Vitamin D also did not explain the observed inequalities in fully-specified models [75].

Levels of severe mental illnesses are higher in ethnic minority groups, and they also experience a higher risk of being hospitalised for these conditions [84]. A recent preprint showed that risk of COVID-19 hospitalisation is greater among those with psychological distress, or poor mental health [122], while mortality rates of those detained under the mental health act have doubled compared with the same period last year, and almost half of those death being COVID-19 related [123]. Given the much greater risk of such detentions for ethnic minority people [124], and the observation from a preprint study that levels of psychological distress were higher for non-white groups at the start of lockdown [125], this may contribute to ethnic inequalities in risk of COVID-19 related mortality.

5.1.2.4. Access to services

One of the concerns raised by stakeholder engagement events held by Public Health England was that ethnic inequalities may be exacerbated by limited access to healthcare services [126], with people from ethnic minority backgrounds experiencing more barriers and having poorer experiences of past treatment [127]. There was a particular concern that levels of testing may be lower for certain “hard to reach” (perhaps better described as “hard to listen to”, “seldom heard” and, consequently, “underserved”) ethnic minority groups [128]. Indeed, a letter describing a small study in Sheffield suggested that levels of COVID-19 testing were lower than expected for ethnic minority older patients [129]. One of the factors lying behind this that was identified in this stakeholder engagement was a lack of trust of NHS services, or not feeling that concerns about PPE and testing are being addressed [126].

5.1.3. Findings from the Public Health England evidence review

To begin to provide an evidence base to develop policy to address ethnic inequalities in COVID-19 related mortality, Public Health England (PHE) was commissioned by Government to conduct a rapid review into COVID-19 related health inequalities [69]. The PHE review was based on the most recent surveillance data available to PHE. Despite the initial indication of a focus on ethnicity, its remit was widened to explore several additional factors, including age and sex, residential area, deprivation, occupation, other health conditions and care home residence. In terms of ethnicity, the review produced a relatively brief summary of existing evidence, confirming the extent of ethnic inequalities in risk of COVID-19 complications and mortality. However, the limited analysis of ethnic inequalities in the review’s published findings, along with it not identifying appropriate recommendations to address the observed ethnic inequalities, resulted in it being received with some criticism [130] [67]. An originally unpublished element of the review that focused on ethnic inequalities, and contained a review of a wider literature alongside findings from a stakeholder engagement exercise aimed at understanding the factors that may be driving the observed ethnic inequalities, was later released [126]. The main causal themes that emerged from this research were:

1. Longstanding ethnic inequalities were exacerbated by COVID-19
2. Ethnic minority people faced increased risk of exposure to and acquisition of COVID-19
3. Ethnic minority people faced increased risk of complications and death from COVID-19
4. Racism, discrimination, stigma, fear and trust experienced by ethnic minority communities lay behind these increased risks.

The factors that might underlie ethnic inequalities in COVID-19 risk that were identified by this Public Health England report were that individuals from ethnic minority groups are more likely to:

1. Have occupations with a higher risk of COVID-19 exposure;
2. Use public transportation to travel to their essential work;
3. Have experienced historic racism and poorer experiences of healthcare or at work, making them less likely to seek care;
4. Be less likely to speak up when they have concerns about PPE or risk when working as NHS staff, due to the historic racism;
5. Face challenges in their housing conditions.

However, although this work underpinned the importance of considering the role of racism, it indicated more needed to be done to understand the factors that shape ethnic inequalities in COVID-19 related mortality.

5.2. Access to information, health and social care, and essential services

Healthwatch Haringey produced a report on the impact of the Covid-19 pandemic on the Turkish and Kurdish communities, with particular attention paid to social and economic barriers, as well as health inequalities, faced by this community during the lockdown [131]. Haringey has a relatively large population of Turkish and Kurdish people living in the borough, with pre-COVID-19 challenges that included language barriers, comorbid conditions and limited understanding of routes into healthcare and other services. The research and consultative processes included interviews and a survey with staff and volunteers across ten VCSE Turkish and Kurdish organisations in Haringey and Enfield. The outcome of the consultation process revealed how Covid-19 had heightened existing challenges, including:

- Turkish and Kurdish communities were more likely to face language barriers and have interpreting needs that may limit their access to information. Language barriers therefore were key to the Turkish/Kurdish communities being able to access information, especially with regards to COVID-19 and consequent changes in how health and social care services were organised and run.
- Analyses indicated that the Turkish communities were making proportionately greater use of Accident and Emergency services, suggesting poorer access to other health services.
- That the organisations and religious worship centres that served the Turkish and Kurdish communities were crucial to disseminating health information.

Language barriers were also identified as a crucial issue by the Anti-Tribalism Movement in its work with the Somali population [116] They estimate that 60-70% of the older generation of Somali people speak little or no English. So, they are unlikely to call the NHS helpline for advice if they or their loved ones are symptomatic. And, the few Somali elders who have been admitted to hospital with COVID-19 were reported to have had traumatic experiences, being unable to speak to or understand staff, unable to use family members to interpret as visitors were not allowed, and, of course, then being at risk of dying alone without being able to express themselves.

There are also concerns that women in certain religious communities may be reluctant to access healthcare, due to insufficient healthcare provision meaning that the culturally appropriate segregation of genders is not possible [132].

The need for good access to information and services was also identified in a survey with 360 participants conducted by the Croydon based Asian Resource Community Centre (ARCC), but this also identified the importance of access to a range of services addressing basic needs [133]. In summary the study found:

- Among young people, those who were white identified information, advice and guidance as a key need, whereas young Black and Asian respondents said their biggest need was being able to shop and access food banks.
- Black 26-40 year olds reported that their biggest needs were shopping, finance, and Information advice and guidance. Specifically, the Black African community identified finance as a big need alongside mental health support.
- Of the 26-40 year olds who identified as Asian, the majority indicated that shopping, food bank, medication and education were their priorities. Of those who said a food bank was their biggest need, they also felt strongly that communities and health should be a government priority. This group also indicated that there was a need around young people, poverty, housing and employment.

A survey conducted by BAMEStream found that 51% of responding ethnic minority led organisations were offering bereavement and trauma support, with the likelihood that this may increase as the pandemic continues [134]. This was occurring in the context of mainstream providers recognising that: there is a lack of cultural competence in their work; questions of equality do not factor into decision making when commissioning services; and they identified a need to build capacity for ethnic minority service providers.

5.3. Economic and educational inequalities

Ethnic minority groups in the UK experience marked socioeconomic inequalities that have remained persistent over time, even if the extent and nature of this varies across groups [89]. With very few exceptions, most commentators agree that these inequalities place ethnic minority people at higher risk of severe illness and mortality from COVID-19, as well as being more likely to experience harsher economic impacts from the measures used to slow the spread the virus.

The ethnic inequalities in health previously described exist in tandem with, and are caused by, a variety of socioeconomic disadvantages in terms of labour market participation [135], unequal pay [136], child poverty [137], wealth [138], housing conditions [115], home ownership [139] and local-area deprivation [140]. Indeed, these inequalities have widened over the current context of ten years of austerity in public spending and investment, which has had a disproportionate impact on the poorest ethnic minority groups [141]. This is reflected in the impact assessment of these policies in London, which projected that on average ethnic minority households would be between £350-£720 worse off in 2021/22 due to tax and welfare changes, while White British households would be £50 better off [29]. In addition, households comprising non-UK nationals were projected to be £370 a year worse off, compared with an on average £10 deficit experienced by households of UK nationals [29]. According to ONS, the freeze in levels of public welfare has caused income inequality to widen during the past two years [142], although there is some evidence that levels of poverty might have reduced during the coronavirus pandemic, in part because of falls in median income (meaning that the level at which an income is classed as poverty has reduced), but in large part because uplifts in benefits have improved incomes for some groups [143]. However, this may have occurred to a much lesser extent in London due to the impact of the benefit cap. So, as a result of the April 2020 uplifts in benefits, 22,000 people living in London became subject to the benefit cap, in addition to the existing 22,300 people in London who were already subject to the benefit cap [144]. Those households will lose an average of £185 per month in benefit awards, rising to £400 for private sector renters with children [144]. The impact of this on ethnic inequalities in levels of poverty have not yet been estimated, however, during the pandemic, economic risk appeared to have been more aggravated for people from ethnic minority groups, who, when asked, were twice as likely to report having lost support from

the government compared with respondents from white groups, yet were more likely to say that financial support from the government would “help people like them” [145].

People from ethnic minority groups are known to be more affected by precarious employment, with younger ethnic minority adults being more likely to be unemployed, on zero hours contracts, or to be doing shift work or having a second job [102]. Indeed, it is estimated that 1 in 13 people from ethnic minority groups overall, and 1 in 8 people from Black groups, are in insecure work, compared with 1 in 17 from White groups [103]. Those from ethnic minority groups are also more likely to have no financial savings [104]. Data collected during the Greater London Authority’s Survey of Londoners 2018/19 showed that just 28% of people from Black groups had savings of £1,500 or more, compared with 63% in White groups and 46% of ethnic minority people more generally [109]. As described earlier, people from White Other, Pakistani and Bangladeshi groups are more likely to be self-employed than the White British population [111], although figures from the 2011 Census indicate that levels of self-employment are lower for ethnic minority people within London, with 19% of the Pakistani/Bangladeshi group being self-employed, compared with 21% of the White group [146]. It is of note that the Greater London Authority is the city region with the highest proportion of self-employed people [147].

Another way in which inequalities in wellbeing manifest is through access to private outdoor spaces. During lockdown, access to public outdoor spaces was limited to relatively short periods of exercise. In June, the Government’s COVID-19 wellbeing guidance reminded people that meeting with others was allowed only in “private gardens or other outdoor spaces” [148]. However, all ethnic minority groups were less likely than the White group to have access to outdoor space at home, with people from Black ethnic groups being almost four times less likely than White groups to have outdoor space at home [149].

5.4. Racism and discrimination

Experiences of racism and discrimination are a central component of the lives of many ethnic minority people. Worryingly, survey assessments of experiences of racism and discrimination show a persistently high levels of risk for ethnic and religious minority groups over time, with no indication that they have dropped in more recent periods. For example, 15 per cent of Black Caribbean people reporting experiencing racist abuse, assault, or vandalism in 1993/1994, compared with 14 per cent in 2000, and 12 per cent in 2008/2009 [150,151]. Similarly, 20 per cent of Black Caribbean people were very, or fairly, worried about being a victim of a racist attack in both 1993/1994 and 2008/2009 [150,151]. And underlying these experiences is a worrying continuation of prejudice in the White population within the UK, which has remained at a consistent and high level over the past thirty years [152]. Coupled with this is a context where, according to the Special Rapporteur to the UN, “ethnic and religious intolerance have become more acceptable” [153], with a doubling in the number of racially-motivated hate crimes in the five years up to 2019 [154], and a steady increase in racist and religious hate crime recorded in London over the most recent months of the coronavirus pandemic period [155]. Very worrying in the current context is that police recording of hate crimes show that those targeted at people characterised as “IC5 – Oriental” increased from an average of around 40 incidents per month to 77 a month in February 2020 and then to 127 a month in March 2020 [156]. Ethnic minority people’s views on levels of racism appear to reflect this evidence of persistence over the last 30 years; a June 2020 YouGov poll found that 86% people from ethnic minority groups thought that racism was “somewhat” or “a great deal” present in UK society 30 years ago, compared with 84% who think that is still the case today [157].

The significance of racism in lives of ethnic minority people was revealed in a Voice4 Change England and ACEVO report on the experiences of ethnic minority charity workers [158]. The report was based on data from an online survey with over 500 ethnic minority people, 24 in-depth interviews, 13 of which were with charity leaders (including two ethnic minority people) and 11 with ethnic minority charity staff, and two roundtable discussions. The report identified concerns over the ways in which racism leads to inequalities. In particular, the online survey showed that racism was a significant feature of the work lives of ethnic minority charity staff:

- 68% of such respondents said that they had experienced, witnessed or heard stories about racism in their time in the charity sector; and
- 50% of such respondents felt that they needed to ‘tone down’ behaviour or to be on their ‘best behaviour’ in order to fit into the charity sector.

In terms of direct experiences of racism, the report showed that:

- 222 people had been subject to ignorant or insensitive questioning about their culture or religion;
- 147 people had been treated as an intellectual inferior; and
- 114 respondents had been subject to excessive surveillance and scrutiny by colleagues, managers or supervisors.

In addition, there is evidence of discrimination against ethnic minority people in the policing of the response to the pandemic. The number of Covid-19 Fixed Penalty Notices issued by the police to ethnic minority people during lockdown was disproportionately high compared with the geographical composition of the population; furthermore, stop and search and arrests of ethnic minority people across London were also disproportionately high during this period [159].

In an online discussion event organised by the Reach Society, a retired former senior police officer raised questions about the policing of communities during the period of the Black Lives Matter campaign and the COVID-19 pandemic. He said:

“... We are going through a period of backlash since the Stephen Lawrence enquiry, especially regards to police on the streets. The focus is police as gatekeepers of the criminal justice systems and their behaviour makes a massive difference. There are some practices taking place now that leaves much to be desired. At this time of a national pandemic instead of making things better they are seen as making things worse, certainly since the Black Lives Matter campaigns. There is racial profiling taking place and is not helping matters when there are genuine fears in the community about disproportionality effect from COVID. It is not to say criminals shouldn't be targeted or arrested, but the heavy handedness meted out to some in the community, where common sense approach would make a difference, they just seem to be pushing using heavy handed tactics that is unjust and disproportionate.

The coming together no doubt of the BLM and the COVID has been a double-edged sword, of which it might seem only one side is being used. I fear it can only get worse as easing down starts to gather pace and they are being pulled in many directions to solve this or that emergent issue arising from people not obeying restrictions. There is the fear that black youths, in particular, could come under greater scrutiny through stop and search as well as fixed penalty notices.”

Given this evidence, and the evidence on racism described earlier, it is perhaps not surprising that stakeholders included in the Public Health England engagement exercise identified racism and discrimination as a root cause in the ethnic inequalities in COVID-19 outcomes; operating through physiological pathways such as stress, as well as structural pathways around access to healthcare [9].

In addition, potential changes in the provision of mental health services are argued to be likely to impact adversely on ethnic minority people, The Coronavirus Act 2020 significantly reduced the protections provided for patients who are detained under the Mental Health Act 1983, enabling a patient to be detained on the judgment of only one approved doctor, extending the length of time a person can be detained in emergency situations, and reducing opportunities for the detention and the treatment received to be examined by a full Mental Health Tribunal. Detentions of ethnic minority people under the mental health act are higher than for white people without obvious reason [160], an inequality that might be amplified by the reduction in the protection of patients' rights [161–163], although these legal changes have yet to be implemented by the Secretary of State for Health and Social Care.

5.5. Community and religious structures

One element of the response to the pandemic was the closure of places of worship, along with the closure of other venues where large numbers of people gather, resulting in some restrictions to access to traditional religious and faith practices, and to community venues. A Report from the Institute of Jewish Policy Research [164] shows that there are concerns within the Jewish community about the impact of this. As the report's author puts it:

"Jewish life involves gathering and interacting in Jewish groups regularly: for daily minyanim, Shabbat services and other communal and social activities. 25% of Jewish adults attend synagogue most weeks; the equivalent proportion for church attendance among British Christians is about 10%. And festivals, such as Purim which was celebrated just a few weeks ago, bring even more people together than usual. These are all perfect environments for a virus to multiply. So physical social interaction – typically the essential, even obligatory lubricant which underpins Jewish life – now poses a mortal threat, and any failure by recalcitrant individuals or sub-communities to shut it down may explain elevated levels of mortality among Jews."

Staetsky [165] notes that certain Jewish subgroups have intense religious lives – congregating in places of worship, engaging in religious study and having large families – all of which make social distancing considerations more challenging to implement. Similarly, a commentator quoted in The Anti-Tribalism Movement report pointed out that *"...the closeness of family ties may have also made social distancing more difficult. Somalis feel compelled to visit sick relatives or bereaved families. Social distancing is alien to us"* [116].

The coronavirus pandemic, and associated lockdown and social isolation measures, have significantly disrupted these opportunities to access and provide social supports, and to organise around community and religious identities. As a member of the Somali community said [116]:

Mosque attendance and group prayer provide emotional, spiritual and social anchoring, and helping to cope with stress and mental illness. Group prayers are particularly important this time of year, with the impending start of Ramadan on April 23 and the daily 16- hour fasts. There is much distress in the community that this will not be possible. Mental health issues may become more pronounced due to this. Mosque leaders rarely know how to reach people in their homes through technology.

In response to this, many religious organisations have adopted online practices [166], and explored other alternative methods of worship [167], although, as described later, this has not always been straightforward.

5.6. Loneliness, wellbeing and mental health

Findings from the COVID-19 Social Study, which has followed respondents' experiences of the pandemic since the first month of COVID-19, found that those from ethnic minority groups were more likely to have been subjected to psychological or physical abuse, as well as having higher levels of thoughts of self-harm and self-harm behaviours [168]. The same study has reported provisional results showing higher levels of depression and anxiety and lower levels of happiness and life satisfaction among ethnic minority people during the lockdown period [169]. A Red Cross Poll also indicated higher levels of loneliness among ethnic minority people; particularly around low levels of neighbourliness, with 52% of ethnic minority respondents reporting that their neighbours felt like strangers, compared with 37% of UK adults as a whole [170]. A study on children and young people found that suicidal thoughts, self-harm and anxiety all increased by a significantly higher amount in ethnic minority children and young people compared with white children and young people [171]. Survey data from London showed that the proportion of those feeling lonely was higher among ethnic minority people (11%) than White British people (6%) in April 2020, although this gap closed by May 2020, so the significance of this difference is hard to interpret [172].

The work of BAMEStream (an alliance of practitioners, therapists, policy specialists, organisations, activists, and academia, who specialise in the areas of mental health and wellbeing and whose core purpose is to bring the mental health needs of the community into the mainstream) identified the impact of COVID-19 on the mental health and wellbeing of ethnic minority people. They conducted a survey that covered NHS Foundation Trusts, Local Authority commissioners of health and wellbeing services, as well as community based charitable organisations, across England and Wales, of which 53 were London based organisations [134]. One of the key conclusions of the report was that:

“A mental health epidemic is coming and BAME communities are likely to be at the forefront” and “...we could be looking at a mental health epidemic as a direct concomitant impact of COVID-19, for which BAME communities could be disproportionately impacted upon, unless something can be done to ‘protect’ those likely to be affected”.

All but one of the 70 participants who responded reported a significant increase in casework related to stress, anxiety and loneliness as a direct result of isolation and the impact of COVID-19. This suggests, not only is there a need to seek ways to address and support those exhibiting heightened anxiety and stress as a direct consequence of the restrictions to what we took to be a 'normal way of life' pre-COVID, but also a need to address how to deal with those symptoms as the changes in the extent of lockdown happen.

5.7. The Gypsy, Roma and Traveller population

The Gypsy, Roma and Traveller community have continued to be faced with a range of disadvantages, including discrimination, poorer health, and poorer labour market and educational outcomes [173]. However, quantitative data on COVID-19 related outcomes for this group is generally missing, because data on this ethnic group is generally subsumed into that for the “White Other” ethnic group. This is, perhaps, because of the small sample size for this group. For example, an ONS report showed that 16 COVID-19 related deaths occurred among the Gypsy, Roma and Traveller population between 2nd March and 15th May [70].

In terms of service delivery, this group is often classed as “hard to reach”, although, as described earlier, “hard to listen to”, “seldom heard” and, consequently, “under-served” might be more apt

descriptions, with, for example, Gypsy, Roma and Traveller people being routinely excluded from survey data [174]. There are concerns that the Gypsy, Roma and Traveller community may be affected by the unfeasibility of restrictions to non-essential travel, and that COVID-19 may exacerbate the already considerable barriers faced by the community in accessing healthcare [175]. There are also concerns that members of the Gypsy, Roma and Traveller community who are considered “extremely vulnerable” by the Government definition may not have received the official advice sent to others [176]. Due to the lack of official advice provided to the Gypsy, Roma and Traveller community, 30 organisations, led by Friends, Families and Travellers, sent a request to Government for support and clarification over how to manage self-isolation in the face of threat of eviction and limited access to water and sanitation [177], but in the meantime have provided advice themselves, though with limited capacity [178]:

At the beginning ... because of lack of information, many Roma were influenced by the huge influx of fake information on social media, believing this virus is not that serious. We have started calling community members and discovered families with Coronavirus. We have noticed community members, infected, being extremely worried. We have limited capacity to reach out to community members in terms of language. Our current project team is formed of Polish and Polish Roma speakers only. Therefore, we are missing on engaging with our Romanian Roma and Slovakian Roma communities.” [Gypsy, Roma and Travellers Support Group]

Consequently, the COVID-19 related risks, including social and economic consequences of the coronavirus pandemic, have not been adequately investigated for the Gypsy, Roma and Traveller group, and people in this group have been under-served in the response to the pandemic.

5.8. Migration status

Data from the Understanding Society COVID-19 survey demonstrated that ethnic minority migrants were significantly more likely than White British people to have lost their jobs during the lockdown, and were more likely to have experienced adverse changes in their financial circumstances [179]. Among this group are those with No Recourse to Public Funds (NRPF), an already vulnerable group, who are likely to be particularly vulnerable during COVID-19 for a number of reasons. First, those who have lost their jobs during COVID-19 have a high risk of becoming newly destitute, because they have NRPF, or because they have been working informally and consequently have no access to state supports. In addition, because of international travel restrictions they have had no opportunity to return to their country of origin, as they might previously have done after a job loss [180].

Second, although COVID-19 treatment has been exempted from hospital charging, some asylum seekers and undocumented migrants have been reported to be avoiding hospitals, because they worry that they will be charged if their symptoms are not a consequence of COVID-19 [180] They are also reported to have concerns about their NHS data being shared with the Home Office, leading to increased risk of detention and deportation [180] Third, such ‘hostile environment’ policies have not only eroded trust in healthcare services, but also caused issues with housing, where ‘right to rent’ checks have resulted in undocumented migrants often being obliged to rent from illegitimate landlords. Such landlords do not, of course, have the support to offer flexibility in payments to tenants facing financial challenges during the COVID pandemic, resulting in an increased risk of eviction. This has contributed to the large number of people that have been reported by VCSE organisations as being newly destitute and homeless due to COVID-19 [180].

In this context, the Local Government Association, representing councils within the UK, have called for a suspension to the NRPF policy [181], and some local authorities have ensured the provision of emergency accommodation to people in this situation [182].

The issues facing migrants were revealed by an online survey conducted by Kanlungan, a Filipino based VCSE, over May and June 2020, with 78 respondents and 15 follow-up interviews [183]. Their work is particularly important given the high COVID-19 related death rates among the Filipino community, which is a relatively large group, with approximately 200,000 Filipino nationals currently residing legally in the UK and Filipinos currently being the second largest non-British national group employed by the National Health Service. From their survey they found that:

- 89% of participants did domestic and care work, with many working part-time across occupations.
- ‘Precarious’ migrants, including those without legal status (known in the community as undocumented), or with no right to work or recourse to public funds, were at greatest risk as many of the initiatives put in place by the government to mitigate the effects of the pandemic for at-risk populations, employees, businesses and tenants did not take into account these groups.
- The hostile immigration environment policies of the government [184]:
 - Pushed precarious migrants into temporary, overcrowded housing conditions that made social distancing impossible and put them at risk of contracting and spreading the virus.
 - Created constant fear and isolation that separated precarious migrants from support networks and was damaging to their mental health, without recourse to mental health services.
 - Forced precarious migrants into informal, exploitative employment. “No work no pay” meant that people were caught between the dangers of contracting or spreading the virus at work or falling into destitution.
 - Deterred precarious migrants from seeking healthcare, due to the fear of being reported to immigration authorities and being charged prohibitive costs for treatment.

Comments from respondents to their survey indicated:

- Exploitation:
 - *“You’re desperate, you need the money. People take advantage. That’s life.”*
 - *“When you have nothing, you cannot say no. You have to grab the opportunity. They tell you you are lucky, because you have no papers.”*
- Fear and isolation:
 - *“After work I come home, eat, sleep, and then go back to work again. I’ve been here thirteen years, and I’m like a prisoner here. I’ve lost half of my life here.”*
 - *“If I had papers now, I will have trainings. They will benefit from my full service, my full knowledge. I can help in the community, especially now with COVID. The patients need people who empathise, who are concerned. I think I am capable of that.”*
- Unable to travel:
 - *“Imagine if you were in my place. I’m living here for 13 years without going home. It’s very hard.”*
 - *“When my roommate came back [from the Philippines] she hugged me so tight. I said, ‘What are you doing?’ She said, ‘This is from your mum. She misses you so much.’”*

There also concerns that the recent Domestic Abuse Bill proposed to support migrant women with NRPF would not be sufficient to undo the human rights violations that this group currently faces, leaving them unsupported in a time of worsening domestic abuse [185]. The concerns stem from the Home Office’s decision to run a pilot project to assess the needs of migrant women with NRPF, rather than to introduce a comprehensive strategy on violence against migrant women, despite extensive

existing evidence of the abuse faced by many such women, including the High Court ruling that NRPF policy breaches the European Convention of Human Rights [185].

6. Gender

6.1. Risk of infection, complications and mortality

Analyses of COVID-19 related deaths rates occurring up to the end of June, conducted by ONS, confirmed previous findings indicating that the rate of COVID-19 related mortality was higher for men than for women [4]. Overall, the age-standardised mortality rate for men in England and Wales was 65.1 deaths per 100,000 men, compared with 43.3 deaths per 100,000 women, a rate just over 50% higher. However, the difference in risk between men and women was greater at younger ages, being almost twice as high for those aged under 75. The increased risk for younger men was confirmed by data presented by Public Health England, which showed that men of working age were twice as likely to die from COVID-19 as women of working age [69].

This observed increased likelihood of COVID-19 mortality among men mirrors that found in other countries [186,187], although it is not straightforwardly explained. Proposed causes for this difference include pre-existing comorbid conditions, greater engagement in risky behaviours, sex differences in immune response and other biological characteristics [188], with some emphasising specific differences in Angiotensin-converting enzyme 2 (ACE2) receptor sensitivity [189]. However, evidence to support any of these propositions is sparse, and is non-existent for biological differences. More robust is the evidence suggesting that men were slightly more likely to be infected with COVID-19, but not at a sufficiently greater rate to explain gender differences in risk of mortality [73]. And the greater risk of infections was attenuated once socioeconomic, lifestyle factors and comorbid conditions were taken into account [73]. It is also worth noting that estimates of the risk of infection are biased by potential gender differences in the likelihood of being tested for an infection.

In contrast to the increased risk for men of mortality and infection, 77% of the workforce at high risk of exposure to COVID-19 are women, suggesting that if this additional risk faced by women was taken into account, the gender difference would be even greater. For example, social care workers have significantly higher rates of COVID-19 related mortality than the overall population [5], and 83% of social care workers are women [190]. It has also been noted that COVID-19 related mortality rates for healthcare workers and female social care workers are even higher in London than elsewhere in England and Wales [5].

6.2. Pregnancy and reproductive health services

Concerns have been raised that pregnant women were being forced to work in frontline roles, sometimes without personal protective equipment [191]. Indeed, a survey of 3,004 pregnant NHS workers found that 34% of respondents were continuing to work in environments that they considered to be unsafe [116]. Guidance from the Royal College of Obstetricians and Gynaecologists (RCOG) states that women who are less than 28 weeks pregnant can continue to work in direct patient-facing roles, as long as they are not COVID patient-facing [193], guidance that some have criticised, because current Public Health England information states that once infected it can take up to 14 days for symptoms to appear [194]. It has been suggested that pregnant women's willingness to work in potentially unsafe environments may be motivated by fear of discrimination [195], a real possibility given that a report by the Department for Business Innovation and Skills estimated that 54,000 women a year are forced out of their jobs due to pregnancy, with three out of four new mothers reporting a negative, or possibly discriminatory, experience during their pregnancy or maternity leave [196]. This reflects longstanding gender inequalities in the workforce. One possible solution, a bill put forward by Maria Miller MP to introduce legal protection for pregnant women and

new mothers, meaning that such women could only be made redundant in very specific and limited circumstances [197], is, however, unlikely to be adopted by Government [198].

In general, there are very little data on experiences of antenatal care, delivery and post-natal care. What there is suggests a negative impact of lockdown and social distancing on the care received. Pregnant women have lacked normal sources and processes of support, since many expectant fathers, same-sex partners, and other birthing partners, have been excluded from accompanying their partners to antenatal checks, being present at delivery and being present at postnatal checks. This potentially results in vulnerable pregnant women missing out on important support. Jadea⁸, a black trans parent of a 3 month old baby, who was interviewed by the Ubele Initiative [14], offers the following insight:

“When my partner was pregnant and went into hospital it was painfully frustrating, not being able to stay the night with my family. My partner had to stay the night of the birth due to a few complications and because of this lockdown I wasn't able to stay with her or my child, which was very stressful for the pair of us. Getting to the hospital was a nightmare as well.”

And Jadea's partner, Pari, who was also interviewed, commented that:

“It was scary and, because of quarantine, parts of the hospital were closed off and there was not enough staff. It was painful, scary and I had complications but my partner was not able to stay with me and that was stressful. When I went home my parents were concerned about the virus, because I had been in hospital, so I left and we are staying with Jadea, his father and 4 brothers in a small flat.”

And concerns have been raised that of the births from mothers who were COVID-19 positive, 92% were delivered by caesarean section [199], a proportion that has been considered to be unnecessarily high and likely to result from COVID-19 related fear [200]. As a comparison, in October 2019, 29% of babies were delivered via either elective or emergency caesarean section [201].

There have also been concerns that measures to manage the coronavirus pandemic may impact on access to reproductive healthcare [202], with indications that existing problems in access to abortion care have been exacerbated [203]. In March, nearly a quarter of British Pregnancy Advisory Service abortion clinics were forced to close due to COVID-19 related staff shortages [204]. Marie Stopes International estimate that globally COVID-19 could cause 1.2-2.7 million unsafe abortions and 5,000-11,000 pregnancy-related deaths [205], as a result of reductions in access to services [206]. However, there is no evidence of this occurring in the UK, and the Government has been praised for its approval of telemedicine for early abortion care, allowing women and girls to access medication for early medical abortion from their own homes, rather than risk travelling during the pandemic [207].

Nevertheless, remote online care raises a series of potential threats for some women. This is illustrated by comments, from a 58 year old women who was present at one of Efficacy EVA's Menopause Group discussions, on the uncomfortableness of having to conduct a personal examination online [14]:

“I am going through menopause and have been having a tough time with a lot of the symptoms especially the vaginal atrophy, but because there's no doctor appointments so I suffer silently. I'm not comfortable exposing my private parts to a doctor on a screen. The doctor says that they can refer me to the clinic at the hospital for an examination, but I am nervous going to a hospital because of the risks.” (Efficacy EVA Menopause Group Discussion 22/07/20)

⁸ Pseudonyms are used throughout this report.

6.3. Employment and childcare

Prior to COVID-19, women faced a range of disadvantages in the labour market. Assessments of the gender pay gap show that women in paid work receive 18% less per hour than men, a gap that for mothers increases over a period of 12 years after the birth of their first child [208]. Women are also over-represented in part-time employment, with 40% of women working part-time compared with 13% of men [209]. Additionally, women are more likely to be in involuntary part-time work than men, where “involuntary” refers to workers who would work more hours if they were available [210]. As a result of these issues, coupled with the increased risk of women being in low-paid or insecure work, 10.1% of women workers do not qualify for statutory sick pay, more than twice the proportion of men [211].

This disadvantage has been exacerbated during COVID-19, with women being roughly a third more likely than men to work in sectors affected by lockdown; women aged under 25 were particularly badly affected, with 36% of them working in shut down sectors [212]. So, women have been disproportionately affected by unemployment during the coronavirus pandemic, with an Institute for Fiscal Studies report showing that mothers were 47% more likely than fathers to have lost their job or resigned, and 14% more likely to have been furloughed [213]. Reasons for the worsening of these gender inequalities during the coronavirus pandemic may be the dual effect of unequal childcare responsibilities and being over-represented in locked down sectors of work [214]. And women who did not lose their jobs may have been affected in other ways. For example, it has been claimed that at the beginning of lockdown, many pregnant women working at workplaces that could not be made safe due to COVID were put on statutory sick pay, rather than on furlough, resulting in vast lost earnings [215]. Discriminatory practices from employers towards pregnant women, or mothers, were acknowledged as “clearly unacceptable” by the Government in 2017 [216], yet, as described earlier, no legislative steps have been taken to redress this [217]. So, the effect of the coronavirus pandemic on employment may have been particularly severe for pregnant women and mothers.

Asymmetric care-giving responsibilities between women and men were well-documented prior to the coronavirus pandemic. Figures from 2015 showed that women did an average of 4.6 hours of childcare a week, compared with 1.9 hours for men [218]. The same study showed that when other categories of unpaid work were included, women did an average of 60% more than men [218]. In London, prior to the COVID-19 pandemic, the maternal employment rate was the lowest in the country, with mothers being less likely to be in employment than women without dependent children [219]. The inequality in care giving is maintained even when employment status is the same for both parties. And in families where the pandemic has lead both parents to work from home, mothers are more likely to be spending time simultaneously caring for children [213].

The combination of the sudden withdrawal of childcare and a history of unequal division of labour within the home has seen the COVID-19 childcare “crisis” [220] affect women more acutely. In a survey of 19,950 mothers and pregnant women, 81% of women said they needed childcare provision to do their jobs, yet 51% did not have sufficient provision in place to meet this need. Indeed, a lack of childcare provision was said to be a causal factor by 46% of those women who were made redundant, and 65% of those who were furloughed [221]. And this lack of childcare provision is likely to have been particularly disruptive to single parents, who are more likely to be female [222]. A difficulty in accessing childcare might continue, or be aggravated, as we continue to move out of lockdown. The Fawcett Society estimates that 10,000 childcare providers, who offer 150,000 childcare places between them, could go out of business due to the pandemic [223]. This led the chief executive of the Fawcett society to state that unless the Government puts in place interventions to mitigate the

negative effects of COVID-19 on female participation in the workforce “workplace equality will have been set back decades” [195].

6.4. Domestic abuse and violence

The United Nations has described violence against women and girls during COVID-19 as the “shadow pandemic” [224]. At the start of lockdown the domestic abuse charity Refuge saw a threefold increase in visits to its website, which then increased further, reaching ten times the number of visits by May 2020 [225]. A survey conducted by Women’s Aid in April showed that 67% of women who had been experiencing abuse prior to the pandemic said it had got worse during lockdown, with over three quarters saying that lockdown made it harder for them to escape abuse [226]. GLA policing data show a month on month increase in the number of reports of domestic violence, with the number of offences increasing from 7,335 in March to 8,589 in July. This compares with 7,265 and 8,123 in March 2019 and July 2019 respectively [227]. Concerns have been raised that not only will abused women be forced to spend more time with their abusers, but abusers may be using physical distancing measures to restrict partners access to support services [228].

Solace (a domestic violence charity in North London) describe being overwhelmed by demand on their services. The Chief Executive, Fiona Dwyer, noted that:

“We are increasingly worried that women are not able to reach out for help due to being monitored 24/7 by their abuser. We are really concerned about women living in isolation with their abusers and the challenges they face keeping themselves and their children safe. We anticipate that there will be an enormous spike in demand after the lockdown period has ended. Right now, we are at full stretch ensuring that our services can continue to meet the needs of the most vulnerable - keeping our refuges and supported accommodation open to referrals and supporting women to be safe through our community services.” [229]

In the context of increased risk of gender-based violence and abuse, it is a worry that there have been reports of mixed-sex accommodation being provided for vulnerable women, including those fleeing from exploitative situations, because of the lack of specialised female only accommodation. Although, some housing associations have stepped up and supported vulnerable women, including sex workers, it is suggested that there is an urgent need to prioritise the housing needs of those experiencing domestic abuse and violence [230].

6.5. Loneliness, wellbeing and mental health

COVID-19 related self-isolation and social distancing has had a disproportionately severe effect on the mental health of women [231], with evidence that across all age groups women were more likely to report poorer mental health during the coronavirus pandemic than men [232]. While, within London there is evidence that between April and May there was a noticeable increase in the prevalence of loneliness among women (rising from 9% of women to 13% [172]). A working paper by the Institute for Fiscal Studies showed that people with the poorest mental health prior to the pandemic suffered the most deterioration during the lockdown period, with young women being particularly badly affected [233]. Similarly, ONS statistics showed that among people who were clinically extremely vulnerable to COVID-19, women were more likely to report a worsening in their mental health during the lockdown period [234].

The issues women are facing, reported in the sections above, are neatly summarised by this statement from the Fawcett Society [235]:

"The Coronavirus pandemic is exceptionally difficult for everyone and is having a huge impact on all our lives. So far, women and girls in the UK have been largely invisible from the debate and excluded from decision-making. Now schools and nurseries have closed their doors it will be women who take on most of the unpaid care work, reducing their hours or giving up paid work, turning the clock back on gender equality. Many women are on the frontline, delivering essential services, usually the lowest paid or in insecure work. Many women will be trapped in their homes, self-isolating with an abusive partner. It's women who are also more likely to care for older or disabled relatives and neighbours. Yet hundreds of billions of pounds of taxpayers' money is being spent without considering the specific challenges women are facing. Women and girls in all their diversity must be seen, have their voices heard and their needs met."

It is clear that the gender inequalities present during the coronavirus pandemic reflect longstanding inequalities, often enacted through sexist discrimination that is shaped by unequal social structures, underpinned by longstanding process of patriarchy and misogyny. And it seems likely that these inequalities are being amplified by the consequences of policies put in place to manage the pandemic, which do not account for these processes.

7. Sexual orientation, gender identity and gender expression

7.1. Risk of infection, complications and mortality

There are no sources of data available to assess the relative risk for COVID-19 related mortality of lesbian, gay, bisexual, transgender, and queer people (LGBTQ+, the “plus” including those who do not identify with any such label), in part because sexual orientation and gender identity or expression are not recorded on death certificates, in part because they are not recorded on other administrative data, both health and non-health, and in part because the experiences of LGBTQ+ people have not been a focus of any of the major academic health and social surveys conducted in the UK, nor of any of the research projects funded to examine experiences and consequences of the pandemic [210]. This means that no conclusions can be drawn on the level of risk of COVID-19 related mortality, or infection, faced by LGBTQ+ people.

Indeed, one of the striking findings of this review is the lack of evidence on the impact of COVID-19 on LGBTQ+ people, beyond the specialist surveys conducted by LGBTQ+ organisations and small unfunded surveys conducted by academics [210]. Ben Hunt, BBC LGBT Correspondent, in his article ‘Lockdown: Suicide fears soar in LGBT community’, noted that charity organisations have been lamenting the lack of national data on LGBTQ+ people, especially because the lack of data means that their organisations are less able to secure valuable funding to offer help to those who are in need. For example, the chief executive, Ian Howley, of The Health Equality and Rights Organisation (HERO), said “Unless we are counted, we don’t count”, while Emma Meehan, of the LGBT Foundation, said: “Due to the government’s frustrating lack of proper reporting, we’ll never be able to put a true figure on the scale of this crisis” and “The government has however acknowledged the need to improve LGBT data collection on suicide” [236].

Nevertheless, surveys, case studies and other methods used to capture the voices of LGBTQ+ people all show that COVID-19 has significantly impacted on their lives, because, in part at least, of the risks and challenges faced by LGBTQ+ people resulting from various forms of discrimination and disempowerment.

7.2. Access to health care, social care and support services

People who identify as LGBTQ+ are often faced with a range of negative health outcomes, being more likely to have mental health difficulties [237] and certain health conditions [238,239], and have higher levels of substance abuse [240], while at the same time facing a range of barriers to accessing services [241].

A review by the LGBT Foundation reported on difficulties faced by respondents to their survey in accessing sexual health services during a period when clinics were operating at reduced capacity [242]. The indefinite deferral of gender-affirming medical treatments is thought to pose a particular risk for the mental health of transgender and gender non-conforming people awaiting such procedures [243], prompting calls for the prioritisation of gender-affirming care [244].

The Health Equality and Rights Organisation (HERO) and Outlife survey found that almost two in five (39%) of LGBTQ+ people have missed medical appointments during lockdown [245]. For example, a transgender woman, Zoey, spoke about how lockdown affected her ability to access hormones and transitioning services [246]. While Spectra notes that testing for HIV and sexually transmitted infections was been suspended, except for home testing kits [247]. This can be problematic in some

living situations. However, depending on the results, a counsellor was usually on hand to provide face to face counselling. There was also evidence that the number of children seeking counselling in relation to their gender identity and sexual orientation has increased by 12% during lockdown [248], with some of the issues reported being: feeling overwhelmed, fear of coming out, and worsening mental health. A Childline Service Manager reported that “Lockdown has made it harder for many young people to talk openly about their gender and sexual identity or to be true selves at home, especially if they fear reaction from those that they are isolating with” [248].

7.3. Economic and educational inequalities

There are indications that the economic impact of COVID-19 lockdown measures may be felt more acutely by the LGBTQ+ community. Figures from the United States suggest that LGBTQ+ people are more likely to work in industries that have been affected by the COVID-19 lockdown [249]. This is also suggested by the 2018 National LGBT Survey conducted in the UK, which showed that out of the five employment sectors that were most common among LGBTQ+ workers, four have experienced partial or complete shut down due to COVID-19 (Wholesale and Retail; Education; Hotels, Restaurants, Cafes and Bars; Arts, Entertainment and Recreation), that a greater proportion of LGBTQ+ workers were found to be employed in two of these sectors than the general population (Education; Arts, Entertainment and Recreation), and the other of the five most common occupations for LGBTQ+ workers was Health and Social Work, which has been the sector at highest risk of exposure to COVID-19 infection [250].

In the context of potentially unsupportive and potentially abusive home environments, the closure of schools and higher educational establishments may have had an especially negative impact on the lives of LGBTQ+ young people. These are institutions that had previously acted as a gateway to mental health services for LGBTQ+ people and have now become inaccessible [251]. They are also institutions where support from peers may be available, which has a buffering effect on the family rejection that is experienced by many LGBTQ+ young people, by reducing the effect of negative family attitudes and victimisation on anxiety and depression [252].

7.4. Abuse, violence and discrimination

The consequences of lockdown have impacted LGBTQ+ people’s risk of experiencing abuse. For example, in the Health Equality and Rights Organisation (HERO) and Outlife survey, published in The LGBTQ+ Lockdown Wellbeing Report, 15% of LGBTQ+ people reported experiencing violence or abuse during lockdown, with rates being twice as high for Black and South Asian LGBTQ+ people compared with white LGBTQ+ people [245]. Similarly, a preprint report of a study on the experiences of LGBTQ+ people, showed that one in six (16.7%) respondents reported some form of discrimination, which occurred because they were LGBTQ+, since the start of the pandemic [253]. While a review by the LGBT Foundation described various concerns among the LGBTQ+ community, including lack of support, an increase in domestic violence, and a prevalence of unstable living conditions for LGBTQ+ people [242]. For young LGBTQ+ people, survey findings showed that not only have they been unable to express themselves fully at home and have been estranged from their usual support structures, they have also experienced violence and abuse during the period of lockdown [245]. Indeed, they report that 8% of LGBTQ+ young people have felt at risk of homelessness during lockdown.

For LGBTQ+ people, the question of religion and faith has been known to cause internalised conflicts and self-rejection, as well as externalised discrimination and ostracism. Groups such as Sarbat LGBT, which is a support group for Sikh people, provide invaluable services for those experiencing such

conflicts. However, there is little recognition of the difficulties small organisations and support groups have been experiencing in making the move to online services. There are many accounts of intrusions, security breaches and zoom bombing and zoom raiding, which is reported to be incredibly traumatic for LGBTQ+ people of faith/religion who may not have yet come out. These disruptive intrusions, generally conducted by Internet trolls and hackers, into an online video teleconferencing session often includes the insertion of material that is lewd, obscene, racist, or antisemitic in nature, a direct threat to the identities of those participating and typically resulting in the shutdown of the session.

Nevertheless, when such events are safe, they provide positive support, as Sarbat report [254]:

“A few days after the PM announced a country-wide lockdown in the UK, we at Sarbat looked for alternative solutions to continue providing a platform for Sikh LGBTQ+ individuals and our allies to meet and come together. We know that members of the LGBTQ+ community are at a higher risk of feeling lonely and isolated even at the best of times, and this may be particularly difficult for those Sikh LGBTQ+ individuals living with their families that may not be aware or accepting of their sexual orientation or gender identity, with no access to the usual safe spaces. So, we at Sarbat set up an account on Zoom, a video conferencing platform that has seen a boost in users since the Coronavirus outbreak. Although it isn't quite the same as meeting face-to-face, we felt that the online format could allow us to continue serving a social platform for our members from all over the UK and potentially reach people who perhaps previously could not attend our local UK-based events.”

7.5. Loneliness, wellbeing and mental health

Research from other countries describes some themes that may be common to young LGBTQ+ people's experiences in the UK, such as being isolated with unsupportive families, the loss of safe spaces, and a lack of face-to-face identity-based socialisation [255]. A review of the LGBTQ+ literature suggested that parental rejection is experienced by a third of LGBTQ+ young people, with another third not coming out until adulthood [256]. Many LGBTQ+ young people may have been forced to spend more time in home environments where they are not accepted or supported, or may not have disclosed their sexual orientation or gender identity [251,257]. The lack of availability of support for LGBTQ+ people during lockdown has led a UK charity to advise young questioning people to delay coming out until access to their support networks was restored [258].

A web-survey of the LGBTQ+ community reported very high levels of poor mental health, with 72% of the sample reporting having symptoms related to depression [253]. This study also found that having experienced harassment in relation to gender identity, gender expression, or sexual orientation, during the COVID-19 pandemic was associated with a threefold increase in the likelihood of exhibiting significant depressive symptomology [253]. This impact on mental health is evident also from the LGBT Foundation study 'Hidden Figures', which is the largest to date on the impact of the Covid-19 pandemic on LGBTQ+ communities in the UK [242]. The results have uncovered the profound impacts of the Covid-19 pandemic on the lives of LGBTQ+ people, particularly in relation to its impact on mental health (including substance misuse, eating disorders, suicidal thoughts, and isolation) and access to appropriate support, access to health care, missed medical appointments, homelessness, living in unsafe environments, and adverse financial consequences. Those who are living alone during the pandemic wanted support to reduce their isolation through, for example, a befriending service, but said that they would rather receive that support from LGBTQ+ organisations. For example, one participant said: “I'm transgender but not out, my parents are transphobic, having to pretend to be someone I'm not all the time is physically, mentally, emotionally and spiritually exhausting”.

In this context, the study also showed that access to mental health support has been a significant issue, with on average 42% of LGBTQ+ people wanting to access support for their mental health, but with even higher rates for ethnic minority LGBTQ+ people (66%), disabled non-binary people (60%), disabled trans people (57%), and disabled LGBTQ+ people (48%), indicating that those experiencing multiple forms of oppression may be particularly disadvantaged [242]. Indeed, ethnic minority LGBTQ+ people indicated having greater need for access to mental health services, disabled LGBTQ+ people had a higher rate of medical appointments cancelled, and trans and non-binary people were twice as likely to feel unsafe where they are staying.

The mental health impact of the coronavirus pandemic also emerged strongly in the Health Equality and Rights Organisation (HERO) and Outlife survey, conducted between 14th May and 29th May 2020 [245]. They found that:

- Almost four in five (79%) LGBTQ+ people said that their mental health had been negatively impacted by the coronavirus lockdown.
- Before lockdown 24% of LGBTQ+ people said they were depressed “very often” or “every day”. During lockdown this increased to 43%.
- Before lockdown, 34% of LGBTQ+ people said they experienced anxiety “very often” or “every day”. During lockdown this increased to 50%.

The findings of the Health Equality and Rights Organisation (HERO) and Outlife survey also indicates increased levels of anxiety and isolation being a concern for 18-35 year olds [245]. They also described high levels of loneliness in this age group:

- Before lockdown 21% of LGBTQ+ people said they experienced loneliness “very often” or “every day”. During lockdown that rose of 56%.
- And more than two in three (67%) of under 18 LGBTQ+ people felt lonely "very often" or "every day" during lockdown.

They describe this research as showing that that loneliness has itself become an epidemic within a pandemic during lockdown, especially for young people. One participant said: *“I’ve been incredibly stressed out all the time”*, while another said:

“I’m really, really worried that I won’t be able to move out by July and I’ll be stuck in this house with my family for another 6 months. I’m desperate to get out of here. I miss my friends, I miss my boyfriend, and I’m scared all the time thinking about the future.”

And another said:

“My parents have an extremely toxic relationship and are constantly using me as a tool to go between them ... My sister is also incredibly abusive, and I have had to do with the aftermath of her ripping into my step-mum. The constant passive aggression gets directed at me a lot, on top of the general emotional abuse I get for being a gay trans man.”

Support may also be lacking for older members of the LGBTQ+ community, who are twice as likely to live alone as heterosexual cis-gender people, making them more exposed to social isolation [259]. They are also more likely to be single and to have less support from children and extended families. For older LGBT+ people, and those with dementia and their carers, there is virtual support from organisations such as the Rainbow Memory Café, but depending on their circumstances they may have struggles using online technology to access the remote support.

Given this, it is not surprising, though very worrying, that there has been a significant rise during lockdown in the number of LGBTQ+ people seeking suicide-prevention support in the UK and that some LGBTQ+ charities have service users who have died by suicide. Helen Jones, CEO of MindOut, a

LGBTQ+ mental health charity, notes that *"LGBT lives are being lost and we need to know more. It is so frustrating. Recording this data must be a nationwide campaign"*. Indeed, HERO have reported that 11,000 people have accessed its suicide-prevention web pages, up over 44% on the first three months of the year.

8. Socioeconomic position

8.1. Risk of infection, complications and mortality

Countless studies have demonstrated the link between socioeconomic position and health inequalities [260,261]. This social gradient in health outcomes has generally held true during previous global pandemics [262–264]. The latest pandemic is no exception: ONS statistics show that COVID-19 mortality rates for the most deprived decile of areas have been approximately double those of the least deprived decile areas [6].

There are also marked inequalities in COVID-19 related mortality rates by occupation. ONS analysis showed a level of COVID-19 related mortality more than three times higher for men working in elementary (unskilled and manual) occupations compared with those in professional occupations [5]. And over and above this, among men in these elementary occupations the risk of death was three times higher for those in the most deprived neighbourhoods, compared with those in the least deprived areas. Deaths were also significantly elevated for women working in “Caring, leisure and other service” occupations compared with those working in professional roles, and the mortality risk within these occupations also followed a similar gradient with deprivation, with those women living in the most deprived areas having twice the death rate of those living in the least deprived areas.

Similarly, data from the Intensive Care National Audit and Research Centre showed that a larger proportion of critically-ill patients with COVID-19 were from the most deprived quintile of areas (25.0%) compared with the least deprived quintile of areas (14.7%) [265]. In addition, the Public Health England disparities review showed that not only were infections higher for people living in the most deprived areas, but survival rates were also lower [69]. In contrast to these findings, one study that relied on analysis of UK Biobank data, and so was able to use individual-level (as opposed to area-level) socioeconomic measures, found that household income and education were not predictors of infection, although household overcrowding was a predictor [73]. It is possible that biases in the samples included in the UK Biobank study explain the unusual finding in relation to income and education.

One concern around inequalities in COVID-19 related mortality is how they might relate to the increased risk of exposure to infection for those employed in key worker roles. The ONS analysis of occupation related risk of mortality was consistent with this possibility. It showed that certain jobs had a particularly elevated risk for men: Taxi and cab drivers and chauffeurs (134 deaths per 100,000), security guards and related occupations (104 deaths per 100,000) and care workers and home carers (70 deaths per 100,000) [5]. While for women the jobs with a particularly elevated risk were: care workers and home carers (134 deaths per 100,000), nurses (70 deaths per 100,000) and sales and retail assistants (64 deaths per 100,000) [5].

Certain jobs carried an elevated risk of COVID-19 mortality in London compared with elsewhere: age-standardised mortality rates produced by the ONS showed higher deaths in London for those working as sales and retail assistants; taxi and cab drivers and chauffeurs; security guards and related occupations; and health and social care professionals [5]. Data also showed increased levels of mortality among London bus drivers compared with bus drivers elsewhere [266]. Although there was not sufficient data to establish causality, it was suggested that bus drivers may be at higher risk of comorbidities and should as such be offered extended protection against infection. Similar issues may well apply to other occupations with a higher risk.

Household overcrowding is a predictor of COVID-19 infection [73], presumably due to residents in these households being less likely to be able to physically distance, or to self-isolate if they have symptoms. Non-decent, and overcrowded, housing is much more common in lower-income households and for those who rent [267]. Evidence produced by the Greater London Authority, using data from the English Housing Survey, showed that 18% of London households in the lowest income quintile were overcrowded, compared with just 2% in the highest quintile [90].

8.2. Economic and educational inequalities

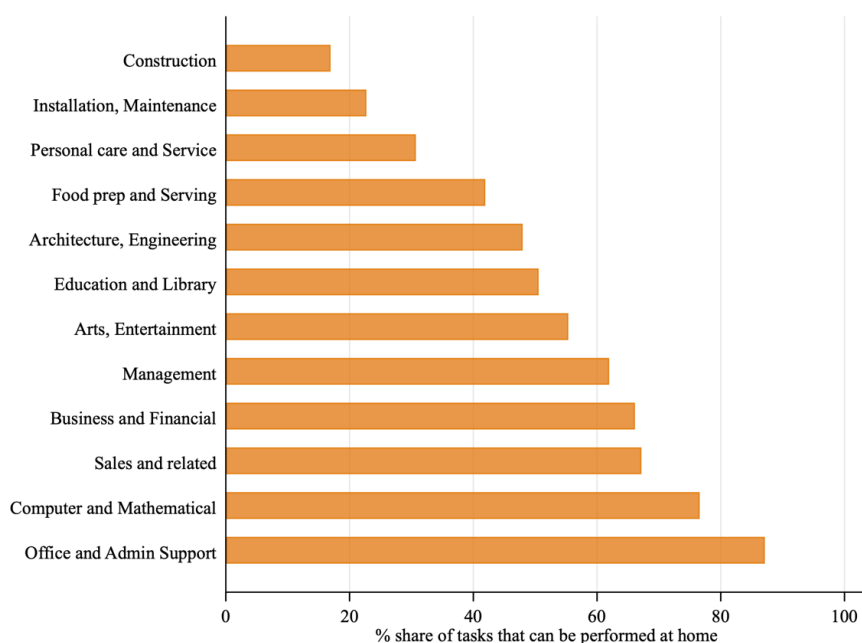
There are concerns that people who are socioeconomically deprived will have to contend with a triple burden from the COVID-19 pandemic; not only bearing the brunt of disproportionate mortality and morbidity, but also being more heavily impacted on by strategies to contain the virus, and then the subsequent economic fallout [268]. Social distancing could not only affect loneliness and employment, but also result in support services being withdrawn from those who most need them [269], and lead to excess deaths among those with pre-existing health issues due to difficulty accessing health services and inadequate care consequently being provided [270]. Some of this has been detailed in previous sections. Here we provide more detail on the impact of the coronavirus pandemic on economic inequalities, particularly through the impact on employment, both through job furloughs and unemployment. However, a crucial part of the context is the pre-existing extent of economic inequalities. As described earlier, according to ONS the freeze in levels of public welfare has caused income inequality to widen during the past two years, with a particularly adverse impact on the poorest [142]. However, there is some evidence that levels of poverty might have reduced during the coronavirus pandemic, in part because of falls in median income (meaning that the level at which an income is classed as poverty has reduced, with no net economic benefit for those who are poorer), but in large part because uplifts in benefits have improved incomes for working families with children [143], and, as described earlier, this may not have benefited those living in London to the same extent, because of the impact of the benefit cap [144].

Estimates by the consultancy McKinsey showed large variation by sector in terms of the proportion of jobs at risk and proportion of furloughed workers. In April, the accommodation and food services sector had 73% of its workers on furlough, with an estimated 68% of jobs in that sector at risk; yet the information and communication sector had just 13% of workers on furlough and 8% of jobs at risk [271]. This reflects great variations across occupations in the ability to work from home, with one study showing that only 17% of self-employed construction workers reported being able to work from home, compared with 87% of self-employed office and administration support staff (see Figure 8.1 for full details) [272]. A survey of 4,931 UK adults showed that the percentage of job tasks that can be done from home was also highly predictive of job loss [273]. The survey also found that people on temporary contracts were more likely to have lost their employment, and that women and less educated workers have been more affected by the crisis [273].

So, those who are unable to work from home risked either furlough, job loss, or facing potentially dangerous working conditions. Those who then went on to develop symptoms would have been faced with a choice to taking a level of statutory sick pay that was unlikely to be sufficient to meet their expenses (£96 per week) [274], or to continue working. Sadly, financial precarity often leaves people with no choice but to take the latter option [105–107]. However, within London, patterns of ability to work from home show that in 2019, workers in London were more likely than the rest of the UK to have ever worked from home (32.1% compared with 26.7%) or to have worked from home in the week prior to being interviewed (16.4% compared with 12.5%) [110].

The London School of Economics Centre for Economic Performance (LSE-CEP) survey of UK self-employment showed the impact of the response to the coronavirus pandemic on self-employed workers, including those working in the “gig economy”. Three-quarters of respondents had less work in April 2020 than they would normally [272]. This fall in work for the self-employed had a socioeconomic gradient: the largest reductions in income were reported to be among lower-income, older individuals. The LSE-CEP survey demonstrated the precarity of those working in the “gig economy”. While, overall, 33% of self-employed workers felt that their health was at risk while carrying out their job, this was the case for 79% of those who source their work through apps, with some citing fear of losing work as a motivating factor in continuing to work despite this fear [272].

Figure 8.1: Ability to work from home by occupation¹



¹Mean responses within self-reported occupation to the question “To what extent can your work be done from home?” where answers are given on a sliding scale of 0 to 100. Source: LSE-CEP Survey of UK Self-employment May 2020

In the context of job insecurity, it is important to take financial precarity into account. This has a distinct socioeconomic gradient, with just 43% of employees in the bottom income quintile having sufficient financial assets to cover a 75% reduction in household income for three months, compared with 75% of employees in the top quintile [275]. In relation to self-employment, the LSE-CEP survey of such workers reported that in April 2020 46% of respondents had trouble paying for basic expenses, such as rent, mortgage payments, or essentials [272]. Furthermore, when asked if they could afford a £500 emergency expense, 20% of self-employed workers in the UK reported that they would have insufficient cash assets to do so [272]. While, figures from London show that approximately 1 in 12 private renters have fallen behind on their rent during lockdown, with an additional 1 in 6 fearing that they will do so soon, equating to approximately 1 in 4 private renters in London potentially facing eviction [276]. Similarly, people who rent experience greater financial risk than homeowners [277], in part because the payment holidays offered by mortgage providers has no equivalent in the rental market, and it is uncertain whether landlords have taken advantage of such mortgage holidays to support their tenants.

There are concerns that it is young people who will suffer the most from the economic impact of COVID-19, with a report for the Centre for Economic Performance detailing the likely “long-term scarring” effects on children and young people due to the long-term unemployment and educational impacts of responses to the coronavirus pandemic [278]. The report highlights the fewer opportunities and declining living standards already faced by young people, and suggests that the consequences of the coronavirus pandemic could exacerbate these issues, resulting in a “dark age of declining mobility” for children and young people [278]. Initial evidence suggests that during the coronavirus pandemic incomes have fallen the greatest for those in the 16-24 and 45-54 age bracket, in part because these age groups were less likely to gain from the uplifts in benefits that have occurred in the short term [143]. Young people may also be those in the most economically-precarious situation, with more than half of 22-29 year olds having no savings [279,280].

In addition, it is thought that educational penalties resulting from school closures may be more severe for families in lower socioeconomic positions, who do not have the financial means for online tuition, or other educational resources, to replace education that is ordinarily provided in person [281], and have poorer access to digital facilities to access online resources.

9. Age

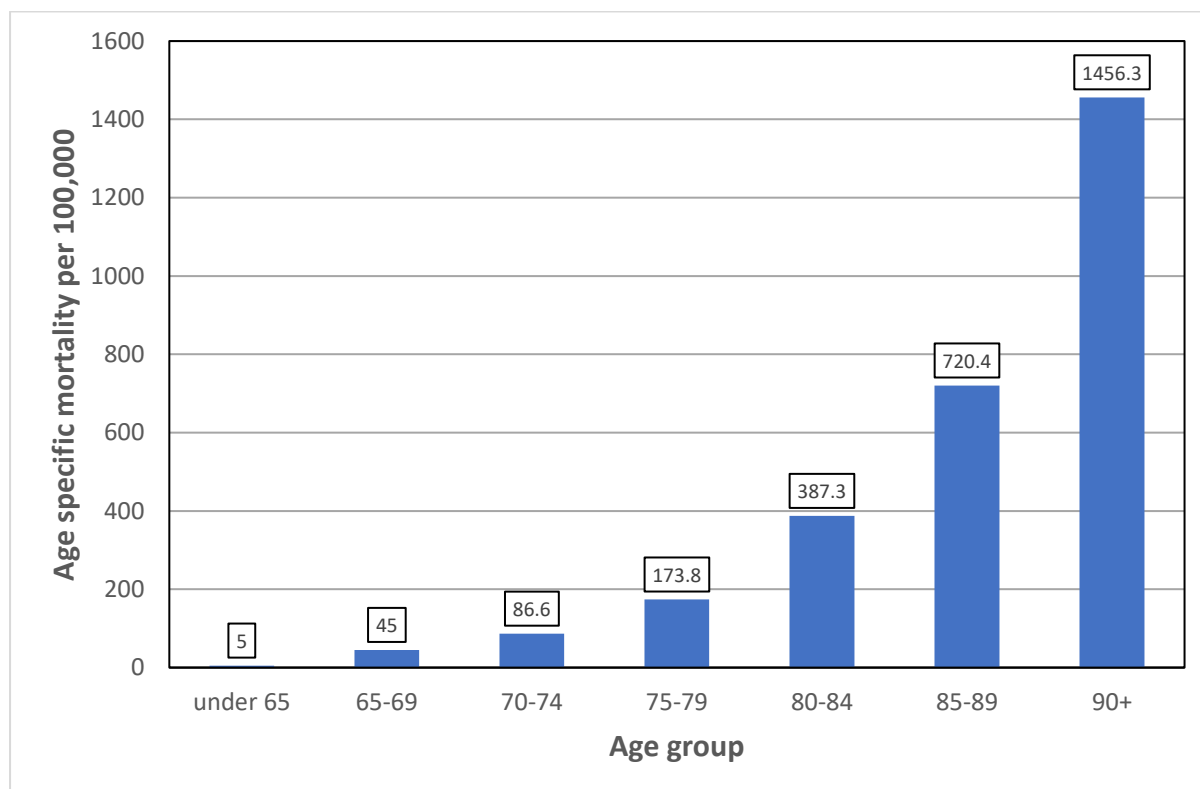
As described in the methods section of the report, the timeframe for this rapid review did not allow for a comprehensive coverage of evidence related to age, because a search that included age-related terms produced many thousands of items. As a consequence, evidence on older adults, and children and young people was less comprehensively covered. However, evidence that was more straightforwardly available, such as that in policy, think tank and ONS reports, and the identification of evidence related to age present in academic papers otherwise identified in the search, meant this review was able to cover age to a certain extent. In this section key evidence related to older adults and to children and young people is summarised.

9.1. Older adults

When initial COVID-19 outcome data were made available from the early stages of the pandemic in China, older age was quickly identified as a predictor for mortality [282]. In England and Wales, ONS have estimated that 92% of COVID-19 related deaths occurred among people aged 65 or over [4], and analysis from the Public Health England review showed that once infected, those aged 80 or over were seventy times more likely to die than those aged 40. In addition, 75% of excess deaths over the period 20th March to 7th May occurred in the 75+ age group [69].

The relationship between age and risk of COVID-19 related mortality is clearly illustrated by more recent data published by ONS, showing age specific rates of mortality for England that occurred in June 2020. These are summarised in Figure 9.1.

Figure 9.1: Age specific COVID-19 related mortality rates, England June 2020 [4]



Another stark early finding from COVID-19 statistics was the high proportion of mortality in care homes, with care home deaths overtaking hospital deaths in May [21]. It has been suggested that this may be due to high levels of comorbidities among people living in residential accommodation, and the inability for complete isolation when receiving physical help, such as washing, toileting and assistance with eating [283], coupled with insufficient PPE provision for care staff [284]. Also potentially relevant was the unintentional discharge of patients who were potentially already infected with COVID-19 from acute hospitals into care homes in order to free up beds for those who might need acute care.

What is clear is that older people are particularly vulnerable to complications and mortality from a COVID-19 infection (as they are from other respiratory viruses) and public health responses to coronavirus should respond to this increased risk. However, responses such as social distancing and shielding might impact to a greater extent on older people's experiences of social isolation, loneliness and mental health. Data from the Understanding Society survey showed that older people living in London were more likely to be shielded than younger age groups, with 10% of those aged 50 or older shielding in May 2020, compared with 6% of 30-49 year olds and 7% of 16-29 year olds [172]. The same survey showed that between April and May there was a noticeable increase in the prevalence of loneliness for those aged 50 or older who were living in London (3% reported feeling recently lonely in April, rising to 8% in May) [172]. One factor that might be particularly relevant in relation to this is that older people are less likely to be digitally connected [285], and this is particularly the case for poorer older people and for older women [286]. Indeed, Age UK, in a statement in May [287], noted that: *"While many people have embraced online forms of social engagement, hobbies and physical activity ... there are still 3.6 million people over the age of 70 who are not online"*. A 65 year old participant in an Ubele Initiative consultation illustrated these issues clearly:

"We haven't seen our grandchildren since the beginning of March – well at least not in person. We have been video calling with them, but it is not the same. The first three weeks were a very emotional time. The realisation of the enormity of the virus really got to me. In addition, a good friend who suffers with Lupus had been in a coma for a couple of weeks and I wasn't aware. I didn't have her address, just her phone number, what alerted me that something was wrong, was her silence on social media. She was someone who posted regularly and having checked with a couple of people we noted she had disappeared. After a bit of tracking on Facebook, we found her brother and it transpired that she had COVID-19 and had been in hospital two weeks before we knew. All together it's been almost two months since her illness; she is still learning to walk and talk again properly. Then one of my husband's close friends phoned, really breathless and rasping one evening. He had spent three hours trying to get through to 111 – and his wife was ill too. He was really panic breathing; you could hear it over the phone. It is personal situations like these that bring it home; that this Virus is so real. Living in London we are more used to its effects."

As noted earlier, support may also be lacking for older members of the LGBTQ+ community, because they are more likely to live alone, and are more likely to be single and lacking support from children and extended families [259].

Also, access to formal sources of support, including health services, might be more difficult for older ethnic minority people, because they are more likely to face language barriers. For example, it is estimated that 60-70% of the older generation of Somali people speak little or no English [116].

9.2. Children and young people

As noted earlier, there are concerns that young people will suffer the most from the economic impact of COVID-19, with an increased risk of long-term unemployment [278]. In addition, inequalities in education experiences and outcomes may have been aggravated, because the impact of school closures may be more severe for children in lower socioeconomic positions, who are more reliant on face-to-face teaching, rather than online teaching and home schooling [281]. This might result in declines in social mobility for children and young people, with a consequent widening of socioeconomic inequalities for this generation [278]. It also appears that incomes have fallen the greatest during the coronavirus pandemic for those in the 16-24 age bracket, in part because of their limited access to the uplifts in benefits that were introduced at the beginning of the pandemic [143]. And those young people who are economically independent are also much less likely to have access to savings to buffer any falls in income [279,280]. This is likely to be particularly problematic for younger ethnic minority people, who at the start of the crisis, as reported earlier, were more likely to be unemployed, on zero hours contracts, to be doing shift work, or to have a second job [102]. These factors, as noted earlier, are likely to produce bigger negative impacts from the economic downturn for young ethnic minority people.

The coronavirus pandemic has also put some groups of young people at higher risk of loneliness and poor mental health. A study on children and young people demonstrated increases in suicidal thoughts, self-harm and anxiety, but all of these increased by a significantly higher amount for ethnic minority children and young people, compared with white children and young people [171].

During lockdown some LGBTQ+ young people faced increased risk of being in unsupportive, or even hostile, home environments, and with less access to peer support. This led to an increase in the number of children seeking counselling in relation to their gender identity and sexual orientation [248], perhaps reflecting the difficulty that LGBTQ+ young people have in expressing their identity at home, especially if they feared a negative reaction from those who live with them [248].

In the context of potentially unsupportive, or abusive, home environments, the closure of schools may have had an especially negative impact, because these often have been gateways to mental health services for LGBTQ+ young people [251].

10. Additional groups facing, or likely to face, significant inequalities

In conducting this review, we identified a number of additional groups who may be at elevated risk, either due to the presence of one or more protected characteristics, or through being in particularly vulnerable social groups, such as prisoners, refugees and asylum seekers and sex workers [180, 228]. Some of these issues, for some of these groups, are discussed in sections above (for example, issues facing migrants). Here we provide some additional evidence.

10.1. The prison population

There have been concerns in the UK that the prison population is being subject to abuse, with one Surrey inmate petitioning the United Nations regarding “horrific” treatment during lockdown [288]. Concerns were raised that inmates with coronavirus symptoms were put into isolation for two weeks with no opportunity to shower or exercise [289]. Following the suspension of all visits, a report by the Parliamentary Joint Committee on Human Rights concluded that this policy “(has) put at risk the right to family life of up to an estimated 17,000 children of mothers in prison” [290].

These issues were vividly illustrated in an interview with Gem, a 34 year old woman who was released from prison one week prior to an interview with the Ubele Initiative, after serving 30 months in prison [14]:

“The biggest problem faced by all the women was the lack of access to address medical needs and access to mental health resources. Medical care was ordinarily diabolical, but the pandemic made it progressively worse.

The Samaritans had trained some prisoners to act as a counselling service to residents in times of distress and crisis, due to the Corona virus this was completely stopped by the prison, leaving the women in a state of distress, panic, anger and frustration which lead to them banging on their doors screaming, shouting and crying, I found it distressing to hear them in such turmoil and without any source of help to reduce and calm their fears and anxieties.

Some of the things they put in place was to cut down association time to just 30 minutes a day which meant in that time residents had to order from the canteen (hygiene products, phone credit, little luxuries), shower, call family/friends, exercise, get fresh air and socialise.

I had a little more freedom because I was in the open part of the prison, but I was able to view, and hear, the repercussions of the time restriction. Being locked up for 23 and a half hours a day lead to lack of mobility, human contact and mental health suffering terribly. I observed ambulances constantly speeding into the prison due to self-harming and suicide attempts, the frequency in which they came was dramatically different than prior to the pandemic. I was also unable to go work or college during this time, which was difficult.”

10.2. Sex workers

As for many other groups, there are no data available on the risk of COVID-19 infections and related mortality for sex workers. Agencies have warned that the health needs of sex workers during COVID-

19 are being side-lined, due to restrictions on outreach services coupled with the financial impact of lockdown [291]. Sex workers with multiple vulnerabilities, such as those who use drugs or are homeless, are likely to face significant barriers to accessing social support [292]. Although some sex workers have been able to move their work online, others may have had no choice but to continue their usual work practices and may feel particularly vulnerable to infection [292]. Migrant sex workers may be particularly at risk, as many are not registered with GPs [291], and some may be asylum seekers only entitled to £37.75 a week in benefits, so forced to continue to work to meet basic financial needs [293].

10.3. Homeless people

Due to poor quality data, it has not been possible to provide accurate mortality statistics for homeless people. Public Health England estimate that the mortality rate for those who are likely to be rough sleepers is 2% of the known male population and 1.5% of the known female population, which is many orders of magnitude higher than that for the general population [69]. Official death statistics for the homeless population are due to be published in 2021, with the ONS reporting that the delay in receiving relevant data is due to many deaths of homeless people requiring investigation by coroner [294].

At the start of the pandemic, the Government implemented a policy to house rough sleepers in emergency pandemic accommodation [295]. They have also signalled their intention to continue providing ongoing support [296]. However, MPs have also warned of “a new wave of homelessness” impacting on the wider population in precarious housing, when the Government’s ban on evictions will end at the end of September [297]. Also of concern is that homeless people seeking accommodation have been reported, by Glass Door (a London charity), to have been turned away by local councils for failing to meet “complicated bureaucratic requirements” [298], though it is worth noting that a strict legal framework determines the actions of local authorities, and when they offer support on a discretionary basis they have had no assurance of additional funding to cover this. These issues were aggravated in the early stages of the coronavirus pandemic, when the Government gave local authorities 48 hours to house all rough sleepers, raising expectations in the context of a real shortage of accommodation.

11. Conclusions

This rapid evidence review has identified substantial inequalities across protected characteristics and socioeconomic position in relation to risk of COVID-19 infection, complications and mortality, as well as in relation to the negative economic, social and psychological impacts of the response to the pandemic. Importantly, these consequences can be traced back to pre-existing inequalities experienced by those with marginalised and discriminated against identities, but they also result from the amplification of these processes of marginalisation, discrimination and abuse that has occurred over the period of the coronavirus pandemic. The diversity of London's population in relation to ethnicity, migration, gender identity or expression, sexual orientation, and socioeconomic position, make these issues particularly important for London.

A focus on the processes leading to these inequalities and their amplification provides the basis for identifying explanations for, and appropriate policy responses to, these inequalities. In seeking explanations for these inequalities, however, it is important to both interrogate proximal (downstream) explanations and to examine how these have been shaped by distal (upstream) factors. For example, in the case of ethnic inequalities in risk of COVID-19 related mortality, focus has largely been on downstream factors. As described in the body of the report, central to the discussion and investigation of these inequalities has been the likelihood that the increased risk results from underlying social and economic inequalities, living in areas and being employed in sectors that increase risk of exposure to the COVID-19 virus, and the greater likelihood to have underlying health conditions that have been linked to increased risk of COVID-19 complications and mortality [89], which in turn are patterned by social and economic inequalities faced by ethnic minority people [82]. However, behind this is the way in which the social and economic inequalities that are faced by ethnic minority people are driven by entrenched structural and institutional racism and racial discrimination [299]. And, importantly, these processes do not operate in isolation, they co-occur and sequentially lead to deepening inequalities in many domains across a person's life course, and are transmitted from one generation to the next [300, 301]. Crucially important is that an explanation of ethnic inequalities in health that stops at social and economic inequalities and doesn't acknowledge and set out to understand how these inequalities have been, and continue to be, underpinned by racism, is limited in its ability to generate solutions to these ethnic inequalities.

Similar arguments apply, of course, to the inequalities faced by those with other protected characteristics, in relations to factors such as disability, gender, sexual orientation, gender identity, or gender expression, and in relation to socioeconomic position. In each case inequalities operate in multiple domains, reflect processes driven by underlying power structures, and accumulate across connected life courses. Developing an understanding of the dynamic inter-relationships between these upstream and downstream processes, and using this to develop appropriate policy analysis, requires an approach that does not simply partial out effects into different components, but rather one that integrates explanatory frameworks to develop an understanding of how different dimensions of inequality interlock to produce adverse outcomes. Important, then, is the need to consider the ways in which various dimensions of inequality interact to amplify increased risks of adverse health, social and economic outcomes in order to identify appropriate policy responses. What is crucial here is the need for both research and policy development to move beyond everyday and common understandings of the meanings of the category labels associated with protected characteristics, and instead focus on underlying processes of power, oppression and discrimination, and how these are reflected in social, economic and political structures and institutions.

Before going on to discuss recommendations for policy responses, however, it is important to revisit the nature of the evidence that we have been able to bring together. The first comment to make in this regard is that this is a rapid evidence review. Although systematic approaches were adopted to

identify relevant information, the necessarily short time frame used for this review means that important pieces of work are likely to have been missed. This is particularly the case for more recent publications (there is an ongoing production of relevant research and reports), and, as noted earlier, in relation to age where the potentially very large volume of publications could not be screened in the available time frame. Nevertheless, the systematic approach does provide grounds for confidence in the conclusions drawn.

The second comment to make is that after a detailed screening of the literature it is immediately apparent how little evidence is emerging from academic, think tank and policy (including Government) sources. Except for data and reports on ethnic inequalities (which themselves are rather limited), there has been no attention, funding, or support given to conducting research to understand how the coronavirus pandemic has impacted on those with other protected characteristics. Although the appendix to this report that catalogues the literature appears large, this is in the context of a search that encompassed all protected characteristics and socioeconomic position. And the research literature is skewed, there is almost no academic/think tank/policy literature on the experiences of and the issues faced by disabled people, or LGBTQ+ people.

The third comment to make is that the quality of the academic, think tank and policy literature is generally poor, reflecting a lack of relevant data, and a lack of capacity within these communities to tackle the issues described above. For example, in the case of ethnicity, it is hard to draw firm conclusions on the extent and drivers of inequalities, because a large proportion of the evidence on hospital admissions, or deaths, has missing denominators, or they are crudely estimated at a national level, rather than estimated from the population from which deaths are counted. In addition, the national data used to calculate denominators are typically drawn from the 2011 Census, which is considerably out of date and almost certainly underestimates the size of the ethnic minority population. The most sophisticated data sources have been developed by ONS, who carried out an innovative death registry and 2011 Census data linkage. However, the use of the 2011 Census data meant that much of the data (including on ethnicity and religion, but also on geographical, socioeconomic, health and other factors) was out of date, making modelling imprecise at best. And such data do not capture those who came into the UK after the 2011 Census, nor adequately track those who have left the UK since the 2011 Census. Equally important in terms of data quality is that the census and administrative data used for these investigations of inequality do not cover other protected characteristics, or do not cover them adequately, as in the case of having to use a measure capturing the presence of a limiting longstanding illness to identify people with a disability. And other data sources that are used to investigate health have a range of similar and additional problems, most notably inadequate samples of those with protected characteristics (beyond gender), including disability, ethnicity, religion, LGBTQ+, and older people. Finally, controversies over the death certification process and which deaths count as COVID-19 related, and biases in who gets a test for infection with COVID-19, means that cautions should be applied to the use and interpretation of even these fundamental data.

The fourth comment to make is the important role of VCSE organisations in filling these gaps in evidence, as well as in addressing gaps in service provision. A scan of the body of the report will rapidly reveal that a large proportion of the evidence that has been brought together comes from VCSE organisations [14], who conducted their own surveys, consulted with their constituencies in a variety of ways, examined how the demands their organisations were responding to were changing, and how their organisations were managing through the crisis [302]. These forms of evidence were then made available through a variety of routes, including surveys, blogs, media commentaries, etc. And these forms of evidence were crucial for this work, not only in bringing people's lives into sharp relief through personal testimonies, but also in providing crucial basic information to map areas of disadvantage and inequality. More detail of this evidence can be found in the Ubele Initiative report

on lived experiences in relation to the coronavirus pandemic [14].

A final comment is to recognise the crucial importance of VCSE organisations in addressing the needs of their constituents during the coronavirus pandemic. Both the advocacy and service provision activities that VCSE organisations have been involved in, as documented in this report, have served to mitigate any aggravation of inequalities experienced by those with protected characteristics. Understanding their role is an important element of understanding the patterning of inequalities during the coronavirus pandemic and how policy responses might be developed. For example, in the case of gender it has been argued, and the body of this report has shown, that the pandemic has served to exacerbate inequalities experienced by women, but there has not been sufficient local and national government investment in resources to counteract this. However, VCSE organisations have played an important role in filling some of the gaps in advice, information, advocacy and services for women, as illustrated by this case study of the London VAWG (violence against women and girls) Consortium, provided by the Women's Resource Centre [303]:

"The COVID-19 crisis has worsened already unacceptable levels of gender inequality and social isolation ... Women's economic well-being, especially among disadvantaged and marginalised communities, has further deteriorated through austerity policies, a zero hours economy and welfare reform ... Women, particularly those with additional protected characteristics have been less able to access needed services during lockdown. As women have come to rely upon online support and to access services, the COVID-19 crisis has illuminated and exacerbated digital inequality. This and other factors mean that, during lockdown, it has often been difficult to reach the most marginalised and disadvantaged women, even by specialist women's VCOs.

In terms of responding to the changing and expanding needs of women, such as increased domestic violence and declining mental health, the COVID-19 crisis has placed new pressures upon already hard-pressed, underfunded and under resourced women's VCOs. The women's VCS in London and across the UK should receive acclaim for how swiftly it reconfigured services in response to lockdown and the expanding and shifting needs of women ... this was not just in response to increasing demands to its own services, but because statutory services have suffered from reduced funding and many had closed.

What has emerged from the COVID-19 crisis is the public sector and women's VCOs working and collaborating to overcome some of the difficulties and challenges of these unprecedented and uncertain times. The COVID-19 crisis and the associated restrictions on public and social life have awakened recognition and respect of women's VCOs in increasing the effectiveness of public services; particularly in relation to meeting the needs of marginalised women and those with multiple and intersecting ("complex") needs.

A key lesson to be learnt from the collaborative approaches during the Covid-19 outbreak, is that women's VCOs and grassroots community groups, whilst needing to retain their independence and specialisms, should be better integrated into local systems in the future. The value of women's VCOs in reducing the chasm of inequalities that will remain in the aftermath of the COVID-19 crisis cannot be underestimated. Ignoring this will be at the Government and public sectors peril."

This point is also illustrated by another VCSE organisation, Keep the Faith, which noted that of the many surveys that were taking place in the early period of the coronavirus pandemic none of them sought to identify its possible impacts on ethnic minority communities or organisations [304]. Similarly, the Asian Resource Community Centre (ARCC) identified the need for good access to information and services to perform its role [133].

Such points raise the question of how the needs of groups experiencing inequalities are identified and, importantly, who can authentically speak about these issues, as well as illustrating the important role in this of VCSE organisations that are close to the communities they support. In partnership with statutory bodies, the VCSE sector could work to establish ‘catalysing bodies’, or infrastructure support and representative bodies, able to bring the voices of respective ‘communities of interests’ together, speaking on key issues affecting equalities across the range of strategic objectives under consideration by public bodies.

Reflecting this situation, ARCC [133], argues that there seems to be specific needs and expectations from particular communities, which leads to the need for a stronger role for VCSE organisations in mitigating the impact of the coronavirus pandemic within the recovery and re-emergence phase. For this to be meaningful, ARCC suggest the need for a long-term commitment to funding going into communities and charitable organisations, alongside a coordinated approach between public and third sector infrastructure organisations.

The importance of VCSE organisations in supporting people through the coronavirus pandemic, and the strain it places them under, is apparent in a report from the Anti-Tribalism Movement (ATM), which indicates that 70% of BAME social enterprises and community organisations, including small Somali charities, experienced a significant increase in demand for their services. They are now delivering food, helping access health and educational support, caring for victims of abuse etc. However, ATM’s consultations show that many charities are in financial distress and may have no resources by the time the pandemic ends, leaving the community “unsupported and disorganized” [116]. A point given national focus by the Ubele Initiative Report, which illustrated the financial risk faced by VCSE organisations [305]. Using responses on the circumstances of 182 voluntary and community sector organisations, of which 137 were BAME-led, over the period March and April, the Ubele report showed that slightly more than two-thirds of both micro BAME charities (those with annual incomes of less than £10,000) and small BAME charities (annual incomes of less than £100,000) did not have any reserves, and fewer than one in five (19 per cent) had reserves that would last three months. Consequently, Ubele warned that as the coronavirus crisis continues beyond the originally anticipated three months, an estimated 87 per cent of small BAME organisations could conceivably cease to operate with an estimated impact of 15,000 to 20,000 service users per week being unable to access services. The report attracted some national attention and spurred on national funding charities, such as London Community Response Fund (Wave 3) [306], Comic Relief [307] and Big Lottery (through Covid-19 Community-Led Organisations Recovery Scheme CCLORS [308] and Phoenix Fund [309]), to recognise its findings and to create ‘funding streams’ targeted to BAME led organisations. We do not yet know the outcome of these funding streams, but we are now close to a situation of widespread financial crisis for VCSE organisations that are representing and supporting those with protected characteristics.

12. Recommendations

The recommendations that are offered as part of this rapid evidence review have been made independently of the funders (the GLA) of this work and have not been approved by them, they are here for consideration. The recommendations are focused on identifying tractable policy solutions in order to prevent, or mitigate, the inequalities in relation to protected characteristics and socioeconomic position that result from the COVID-19 pandemic and policy responses to it. They are drawn from the evidence presented in the body of this report and organised around seven target areas that are relevant across protected characteristics and socioeconomic position, and they focus on processes that can reduce inequality. The relevance of the target areas will, of course, vary across dimensions of inequality and protected characteristics, and the actions that flow from recommendations will need to be adapted to context. Also, it is important to recognise that the agencies with the necessary authority, or responsibility, to identify and take forward actions will vary across the recommendations, though many of these will be, to a greater or lesser extent, within the scope of the GLA. Nevertheless, the target areas and recommendations provide a comprehensive mapping of areas where actions should be developed.

The target areas are:

- A. Reshape the context within which the development and implementation of policy takes place.
- B. Reduce inequalities in risk of infection, complications and mortality.
- C. Reduce the amplification of economic and educational inequalities.
- D. Reduce the risk of domestic abuse and violence.
- E. Protect the rights of those with marginalised identities.
- F. Prevent loneliness and social isolation in vulnerable groups.
- G. Reduce the impact on inequalities in mental health.

Under these seven target areas there are a total of 35 recommendations, with some occasional and deliberate overlap across recommendations. The detail of the recommendations under each of the seven areas are:

A. Reshape the context within which the development and implementation of policy takes place

1. Immediately conduct Equality Impact Assessments on all central and local Government actions in relation to the coronavirus pandemic:
 - Do this in partnership with the VCSE organisations that are providing a range of supports for people with protected characteristics and other vulnerable groups;
 - Ensure that these include recommendations for action to minimise inequalities across protected characteristics;
 - Disseminate these recommendations to all relevant parties within the GLA, ensuring that they are interpreted correctly, and facilitate organisations to implement recommendations; and
 - Act on resulting recommendations.
2. Ensure that other statutory and public bodies conduct similar Equality Impact Assessments, and that private bodies, including providers of care, transport and other employers of key workers, are also encouraged to do this. Offer guidance and support for those carrying out this process.
3. Recognise and acknowledge the importance of understanding the ways in which processes of marginalisation shape the inequalities we observe, document these processes, and disseminate relevant information.

4. Where policy development and research are conducted, move away from that based on stereotyped and reductionist representations of those with protected characteristics and instead focus on how inequalities generated across life courses might be understood and these processes might be disrupted.
5. Invest in (including supporting capacity building) and commission appropriate services from those VCSE organisations that are providing psychological and practical support for people with protected characteristics and other vulnerable groups, such as those who are homeless and former prisoners:
 - Commission services on a long-term basis to provide stability to VCSE organisations and those who use their services, thereby maintaining stability in the workforce and providing space for capacity building;
 - Develop in-house, or externally commission, training programmes to develop capacity within VCSE organisations and provide these for free, or at a subsidised rate;
 - Recognise capacity assessment, or organisational 'effectiveness' schemes (such as Capacity Assessment Schedule (CAS), Lighthouse, etc.) to benchmark VCSE organisations and allow them to demonstrate a minimum level of organisational competence as part of any commissioning process; and
 - Develop opportunities for partnership building with, and across, VCSE organisations to enable VCSE organisations to themselves be grant makers, or to influence the disbursements of grant funding.

B. Reduce inequalities in risk of infection, complications and mortality

6. Place a genuine 'ring of steel' around those living in residential facilities, including those in mental health inpatient facilities and those in prison. This should include appropriate screening for staff and residents, increasing stability of staffing, careful and appropriate management of those coming into such facilities, and ensuring access to plentiful and adequate Personal Protective Equipment.
7. Maintain access to health services in relation to: chronic conditions (hypertension, diabetes, etc.); antenatal and postnatal services; contraception and termination of pregnancy; sexual health; and rehabilitation services. Identify and screen people at high risk of experiencing a chronic condition. Invest in telemedicine to support this, while recognising that this is not a full substitute for face-to-face healthcare.
8. Broaden the definition of 'vulnerable' beyond those who are asked to shield to incorporate all those who have difficulty in accessing services and ensure that these individuals have access to the support infrastructure that is provided during periods of lockdown. This should include ensuring necessary housing, grocery and medical support is provided to those discharged from prison and homeless people.
9. Ensure that risk assessments are carried out for all workers, and that access to Personal Protective Equipment is available to all workers, particularly ensuring that these protections are present for those in frontline key worker roles, in regular contact with users of their services, and those in precarious temporary work.
10. Provide opportunities to access green space and to exercise for those with no or limited access to outside spaces during periods of lockdown.

11. Ensure that access to relevant information is fully accessible – using sign language, large print, translations into other languages, and graphic and audio modes of delivery, etc. Ensure compliance with the 2016 EU web accessibility directive (a legal requirement for public sector bodies from September 2020).

C. Reduce the amplification of economic and educational inequalities

12. Campaign to persuade UK Government to carry out the recommendations in this section.
13. Identify ways to immediately strengthen the social security safety net to mitigate the impact of social and economic inequalities on the health of those in precarious economic positions.
14. Identify ways to provide protections for those not eligible to receive Statutory Sickness Pay, including because of low or intermittent pay and zero-hours contracts, and those who cannot attend work because they are in quarantine or shielding.
15. Identify ways to provide protection for those with No Recourse to Public Funds, in order to ensure that they have access to health care (including providing reassurance on the transfer of data) and the social security and housing support necessary to allow them to socially isolate if they have symptoms of, or a positive test for, COVID-19.
16. Identify ways to provide an economic safety net for people who are shielding and are unable to work.
17. Maximise opportunities to remain in work by providing safe, reliable, regular, accessible and cheap public transport.
18. Maximise access to childcare to mitigate women's greater risk of losing employment with a focus on meeting the needs of women in vulnerable employment positions:
 - Increase the number of free childcare hours;
 - Extend universal free childcare hours to children under three; and
 - Provide heavily subsidised childcare across the age range during school holidays.
19. Prioritise education for those from the most disadvantaged backgrounds, including taking measures to limit digital exclusion:
 - Schools should conduct assessments to identify disadvantaged students and ascertain which resources they may require to engage meaningfully with their education (for example, laptops, stationery, books etc.), and prioritise funding to provide these resources;
 - Ensure all children have access to the internet, with good bandwidth and adequate equipment; and
 - Commission and support VCSE organisations to provide tutoring hubs.
20. Ensure that access to everyday services, shops, transport, etc. is maintained for disabled people including those people with sensory impairments and those who do not meet shielding criteria.
21. Ensure access to affordable healthy food, by putting in place robust grocery logistics (going beyond asking neighbours for help) for vulnerable adults and making sure that vulnerable children entitled to free school meals receive an alternative when these are not available.

D. Reduce the risk of domestic abuse and violence

22. Invest in and commission appropriate services from those organisations that are providing psychological and practical support for people at risk of experiencing domestic violence and abuse.
23. Invest in and commission appropriate services from those organisations with a track record of providing support to those displaying harmful behaviours.
24. Ensure that emergency and longer-term housing support is available for those experiencing domestic violence and abuse.

E. Protect the rights of those with marginalised identities

25. Dissuade local social care and mental health leads from implementing the options under the Coronavirus Act that reduce the protections afforded by the Care Act and the Mental Health Act.
26. Maintain support, including mental health services, for those considering or undertaking gender affirming surgery and hormonal treatment.
27. Ensure that those responsible for enforcing social distancing measures are aware of their equalities duties and receive appropriate training and guidance to avoid the over-regulation of those with marginalised identities

F. Prevent loneliness and social isolation in vulnerable groups

28. Reduce digital exclusion through addressing access to devices and connectivity:
 - Provide free, or heavily subsidised, high-speed internet access to all households, including communal establishments such as hospitals, residential homes and prisons;
 - Make use of public sector assets to deliver affordable future proofed connectivity, including via social housing, community hubs and public transport;
 - Consider strategies to provide free public internet access in areas where access is poor or non-existent; and
 - Support better access to free public Wi-Fi in community spaces, particularly those where access is currently poor or non-existent.
29. Support the online provision of one-to-one and group support for those with marginalised identities, and the online provision of culturally appropriate community and religious activities and celebrations.
30. Prioritise access to supportive education spaces for those with marginalised identities, particularly LGBTQ+ young people and young disabled people.
31. Support opportunities and initiatives that provide the space for those with marginalised identities to meet and provide mutual support.

G. Reduce the impact on inequalities in mental health

32. Invest in and commission appropriate services from those organisations that are providing psychological and practical support for people with protected characteristics.
33. Reduce digital exclusion so that online mental health and support services can be more readily accessed.
34. Support the online provision of one-to-one and group support for those with marginalised identities.
35. Commission VCSE organisations to provide safe spaces that are adequate to host group support and therapy services.

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