



A Rapid Needs Assessment of Excluded People in England During the 2020 COVID-19 Pandemic

MAY 2020

Foreword

The Covid-19 pandemic has become a major concern for every living soul on earth. Yet its different impact on people's health and wellbeing brings some enduring questions back about service provision, especially for excluded groups; asylum seekers, refugees, the homeless and many people in our society. As someone who had to put in extra effort to navigate the healthcare system to fulfil my wellbeing, I strongly believe in the timely importance of this report in bringing excluded human beings back into focus. Lives are at risk. GPs, hospitals and public authorities need to work closely together and communicate frequently to ensure everyone is included in the policies and services provided. This report shows why we really need a stronger approach to make sure the right, accessible information, and support, reaches every corner of our community. This is only possible with the right training and awareness. It offers a unique reflection on the new reality created by this disease, and why we need collaboration and inclusion more than ever.

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DEFINITION OF KEY TERMS

Hostile Environment

A suite of policies introduced by the UK Home Office designed to restrict access to public services, housing and financial services for people living in the UK without leave to remain

Visitor and Migrant Cost Recovery Programme

The costs applicable for NHS treatment received by people living in the UK who do not meet an ordinary residence test. Charges are levied at 150% of the NHS tariff

Shielding

A practice whereby people who identify/are identified as having a clinical vulnerability which increases their risk of an adverse outcome if they contract COVID-19 stay at home for a defined period, usually for 12 weeks

Section 95 support

Accommodation, and £37.75 per week received by people seeking asylum, provided by the Home Office via a preloaded payment card (ASPEN)

Section 4 support

Accommodation, and £35.39 per week received by people refused asylum who meet certain eligibility criteria, provided by the Home Office via a preloaded payment card (ASPEN), which cannot be used to withdraw money and is redeemable in certain shops

Recourse to public funds

Access to state benefits including universal credit and child tax credit

ACRONYMS

BAME	Black, Asian and Minority Ethnic
COPD	Chronic Obstructive Pulmonary Disease
CVS	Community and Voluntary Service
DHSC	The Department for Health and Social Care
DOTW (UK)	Doctors of the World
EBE	Expert by Experience
GRT	Gypsy, Roma and Traveller
HMPS	Her Majesty's Prison Service
MAT	Medication-assisted-treatment
NFGLG	National Federation of Gypsy Liaison Groups
NGO	Non-governmental organisation
NHSE	NHS England
NHSI	NHS Improvement
PEH	People Experiencing Homelessness
PHE	Public Health England
UASC	Unaccompanied Asylum Seeking-Children
WHO	WHO

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1. INTRODUCTION

The COVID-19 pandemic has swiftly changed the world. Since the virus causing the disease was first identified in China in December 2019, it has spread rapidly and impacted the lives of people globally. At the time of publication, in England alone, there have been over 35,000 deaths as a direct result of COVID-19 disease. The indirect impact of COVID-19 on morbidity and mortality will not be fully known for many years but experts agree it will be significant.

Background of COVID-19 pandemic in England and response measures

The first case of COVID-19 in England was noted at the end of January 2020. Transmission within the country became established in late February, and by the middle of March, it had become clear that the risk was high and significant control measures to reduce spread would be necessary. Guidance on self-isolation, social distancing and the protection of people more vulnerable to the disease was introduced. The NHS announced plans to reorient its services and free up space for people needing care for the disease.

On the 23rd March 2020, the UK Prime Minister formally announced a number of restrictions, including guidance on staying at home, except for essential activities; bans on all non-essential travel; and the shutting down of the majority of venues, facilities, amenities and places of worship. The period of these restrictions, initially announced for three weeks but since extended, has been referred to informally by many as 'lockdown'.

These measures have been acknowledged to have had a huge impact on people's lives, with some feeling these effects more profoundly than others. It is clear that people within the most socioeconomically excluded groups are facing disproportionate disruption and hardship due to COVID-19 and the response measures, what is not known is the extent of this.

Doctors of the World

Doctors of the World (DOTW) UK is part of the Medecins du Monde international network, an independent humanitarian movement. Doctors of the World UK has been a registered charity in England and Wales since 1998 and runs clinics providing medical care, information and practical support to people unable to access NHS services. Our patients include refugees, people seeking asylum, people who have been trafficked, people experiencing homelessness, sex workers, migrants with insecure immigration status and Roma, Gypsy and Traveller communities.

Aim

The aim of this rapid needs assessment was to urgently identify and describe the needs of routinely excluded groups, arising from the COVID-19 pandemic in England, to raise awareness, inform advocacy and form recommendations for action.

2. METHODS

2.1 The study team

This rapid needs assessment was conducted by three independent public health specialists and coordinated by a Senior UK Policy officer from DOTW UK as project lead. The work was overseen by a steering committee of DOTW Board and team members.

2.2 Selection of groups

Key population groups in England were selected for inclusion in this needs assessment, based on the following criteria:

- Existing knowledge that they are routinely excluded from healthcare or face significant barriers in healthcare access
- Groups with limited or no representation in current UK research or assessments examining the impact of COVID-19
- Groups experiencing significant vulnerabilities in their circumstances

The selected groups are detailed in Table 1, with a short description. Some people can belong to multiple groups and children can also be part of many of the identified groups.

Table 1: Groups included within the rapid needs assessment

Groups included in assessment	Description
Recently resettled refugees	A refugee who is identified by the United Nations and who is transferred from the country in which they have sought protection in the UK which has agreed to admit them as refugees with permanent residence status.
Newly recognised refugees	A person seeking asylum who has recently been granted refugee status in the UK. For the purposes of this report, this refers to people who have become newly recognised during the COVID-19 pandemic.
People seeking asylum	A person who has departed their country of origin and officially applied for asylum in the UK but is awaiting a decision on their request for refugee status.
Unaccompanied asylum seeking children	A person under 18 years, or in the absence of proof-of-age documents is believed to be under 18, separated from both parents and without a guardian, nominal by law or custom, who is applying for asylum in their own right.
Refused asylum seekers	Someone whose claim for asylum or claim under Article 3 of the European Convention on Human Rights, has been refused and any subsequent appeals have been unsuccessful.

Undocumented migrants	Foreign born nationals who do not have the right to remain in the UK. This includes persons who have entered the country through regular and irregular means, including people who have remained beyond the permitted period. People who have been trafficked; refused asylum-seekers who have remained beyond the permitted period; and children born in the host country to undocumented migrant parents.
People recently released from immigration detention	For the purposes of this report, this refers to people who have been released since the start of the COVID-19 pandemic. Detained foreign nationals for the purposes of immigration control include: <ul style="list-style-type: none"> • Asylum seekers who have had their claim refused • People who have overstayed or breached the terms of their visas • Foreign nationals who have completed a prison sentence and are awaiting deportation
People affected by, or survivors of trafficking or modern slavery	Modern slavery is the severe exploitation of other people for personal or commercial gain. Human trafficking is a form of modern slavery and is the movement of people by means such as force, fraud, coercion or deception, with the aim of exploiting them.
People experiencing homelessness (PEH)	Individuals without stable, safe, permanent, appropriate housing, or the immediate prospect means and ability of acquiring it. Includes those living on the streets, sofa surfing and those in temporary accommodation such as night shelters.
Gypsy, Roma and Traveller communities	‘Gypsy, Roma and Traveller’ encompass a wide range of individuals who may be defined in relation to their ethnicity, heritage, way of life and how they self-identify. This includes: English or Welsh Romany Gypsies, European Roma, Irish Travellers, Scottish Gypsy Travellers, Show people, People living on barges or other boats, People living in settled accommodation, New Age Travellers.
Sex workers	Sex workers are people who receive money or goods in exchange for sexual services, and who consciously define those activities as income generating even if they do not consider sex work as their occupation.
People recently released from prison	For the purposes of this report, this refers to people who have been released since the start of the COVID-19 pandemic. This includes those released on bail, those who have been released early on parole and those released after having completed their prison sentence.

2.3 Recruitment of participants

The project lead identified DOTW staff members to invite for interview based on their knowledge of and experience of working with the groups included in the study. Further organisations who work closely with the above groups were identified. Key informants were contacted with information about the assessment and included if they were available within the time constraints.

Organisations were also asked to identify individuals from the selected groups in Table 1. These experts by experience (EBE) were then linked with the team and provided with information about the assessment. Participation was entirely voluntary.

Further invitations to participate were made during data collection to ensure as full coverage

of the experiences of the selected groups as possible.

2.4 Data collection

Data collection occurred between Thursday 16th April and Wednesday 6th May 2020. Three methods were employed: interviews, survey questions and secondary data.

Interviews, focus groups & testimonials

The bulk of the data was collected through semi-structured interviews and focus groups with key stakeholders and EBEs over the phone or virtually. Focus groups were undertaken for multiple members of the same organisation or EBEs representing the same group. Submission of a testimonial was offered as an alternative for people unable to participate in an interview.

Interview topic guides were developed to focus on the following themes:

- Key health needs of chosen groups prior to the COVID-19 pandemic
- How changes during COVID-19 have impacted people's access to healthcare and other essential services
- Impacts of COVID-19 regulations on health and wellbeing
- Recommendations for stakeholders on how to mitigate the impact of COVID-19

The interviews and focus groups were conducted by study team members trained in qualitative methods. Interviews and focus groups lasted between 45 and 80 minutes. All participants provided written or verbal informed consent. Written notes were made during the interviews and the audio recordings made for transcription purposes. Permission was obtained to use direct quotes within the report and stakeholders were asked how they would like quotes attributed. EBE quotes were all anonymised. All information has been stored securely and will be deleted on finalisation of this report.

Emergent themes were explored further as data collection proceeded and the team regularly convened to discuss findings to inform further interviews and ensure consistency.

Despite the team's concerns about the needs of children experiencing vulnerable circumstances, due to ethical and logistical constraints, no children were interviewed in this assessment. Second-hand information about the experiences of children was captured.

Survey

Two survey questions about the impacts of the pandemic on people engaging with their services were asked to users of DOTW translated advice, via email and social media. The recipients of this survey included NHS health professionals, non-government organisations, asylum support staff, legal advisers, law enforcement and local authorities. This enabled engagement with additional stakeholders. The survey responses were reviewed alongside the interview findings to identify emergent themes.

Policy Review

The policy & advocacy specialist at DOTW undertook a rapid review of the policy environment at the outset of the study. This review drew on existing resources compiled by DOTW and a further search and review of new policy and guidance emerging during the COVID-19 pandemic. The review highlighted potential impacts on excluded groups which were then further explored in the interviews undertaken. Where unusual or surprising findings emerged through interviews, policy was again reviewed to compare practices elsewhere in the literature.

Scope

The scope was restricted to allow for a rapid and timely assessment.

Groups

Data collection was restricted to the selected groups, with the recognition that this does not include all groups facing vulnerable circumstances. There was limited capacity to capture the more specific needs of children living in these circumstances.

Geography

This was limited to England to enable focus on the English healthcare legislation, guidance and responses to the pandemic. These differ from those in the devolved administrations.

Time

Data collection was restricted to within a short time frame. This restricted the number of interviews and availability of respondents. It restricted the ability of the team to access people who were not already in touch with an organisation.

Data

Primary data collected for this report was qualitative in nature.

3. BACKGROUND

The purpose of this section is to highlight legislative and administrative changes that have been introduced as a result of COVID-19 that may impact our identified groups. It also sets the scene for the scale of the problems identified in this assessment by providing population estimates of the size of each group included in this report.

3.1 Pre-COVID health inequalities

The groups included in this assessment all experience health inequalities. Although each group experiences unique health challenges, these groups all experience a range of health access issues from legislative barriers to stigma and discrimination. A summary of our identified groups common health needs and their access barriers to health and social care prior to the COVID-19 pandemic can be found in **Appendix 1**.

3.2 Population estimates

It can be challenging to estimate the number of individuals living in the UK for some of the groups included in this assessment. These groups are often excluded or underrepresented in census data or official statistics, for example People Experiencing Homelessness (PEH). For some, it can be difficult to define who is to be included in these groups. Others, by definition, are difficult to account because of their undocumented status in England. Nevertheless, it can be asserted that these groups do form a significant and important part of the population of the UK. Available estimates of the size of these groups are presented in the table below.

Table 2: Population estimates for groups included in the assessment

Groups included in assessment	UK Estimate	Notes
Recently resettled refugees	5,123 (Excl vulnerable children resettlement scheme) ¹	The number of people resettled in the UK in 2019 via The Vulnerable Persons Resettlement Scheme (VPRS), the Mandate Scheme and the Gateway Protection Programme
Newly recognised refugees	15, 091 ²	Grants of asylum, grants of humanitarian protection, and grants of an alternative form of leave in 2019

¹House of Commons. (2020) *Refugee Resettlement in the UK*. Retrieved 15th May 2020 from <https://commonslibrary.parliament.uk/research-briefings/cbp-8750/>

² Office for National Statistics. (2020) *Migration Statistics Quarterly Report: February 2020*. Retrieved 14th May 2020 from <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/internationalmigration/bulletins/migrationstatisticsquarterlyreport/february2020#asylum-alternative-forms-of-leave-or-resettlement>

People seeking asylum	38,700 ³	Figures as of June 2019. UK figure. 32,000 awaiting initial decision, 6700 awaiting the result of an appeal
Unaccompanied asylum seeking children	7,500	In 2019, the UK granted protection or other forms of leave to over 7,500 children ⁴
Undocumented migrants and refused asylum seekers	No recent or reliable estimates of undocumented migrants 45% of asylum claims ultimately rejected ⁵ 24,443 people entered immigration detention in 2019. ⁶	Some refused asylum seekers continue to be supported by the home office, some depart under assistance or supervision by the government, others depart without notifying the authorities, or remain in the UK as irregular migrants. Immigration detention comprises of: undocumented migrants, migrants who have over-stayed their visas, refused asylum seekers and foreign nationals being returned to their country of origin after committing a criminal offense
People recently released from immigration detention	700+	Since the start of the COVID-19 pandemic, between 16/03/2020 and 21/04/2020 over 700 immigration detainees were released. 368 people remain in immigration detention. ⁷
People affected by, or survivors of trafficking or modern slavery	6,985 ⁸	The number of people referred through the National Referral Mechanism in 2019. However, it is impossible to establish the precise number of people affected by modern slavery due.
People experiencing homelessness (PEH)	320,000	Figure from November 2019. Figure includes rough sleepers and those housed in temporary accommodation. People sleeping in unstable, makeshift accommodation or 'sofa surfing' are not included ⁹

³ The Migration Observatory, Oxford University. (2019) *Migration to the UK: Asylum and Resettled Refugees*. Retrieved 12th May 2020 from <https://migrationobservatory.ox.ac.uk/resources/briefings/migration-to-the-uk-asylum/>

⁴ UK Home Office. (2020) Factsheet: Unaccompanied asylum seeking children. Retrieved 15th May 2020 from <https://homeofficemedia.blog.gov.uk/2020/01/15/factsheet-unaccompanied-asylum-seeking-children/>

⁵ The Migration Observatory, Oxford University. (2019)

⁶ GOV.UK. (2020) *How many people are detained or returned?* Retrieved 15th May 2020 from <https://www.gov.uk/government/publications/immigration-statistics-year-ending-december-2019/how-many-people-are-detained-or-returned>

⁷ BBC News. (2020) Coronavirus: UK detention centres 'emptied in weeks'. Retrieved 18th May 2020 from <https://www.bbc.co.uk/news/uk-52560093>

⁸ Office for National Statistics (2020). *Modern slavery in the UK: March 2020*. Retrieved 14th March 2020 from <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/modernslaveryintheuk/march2020>

⁹ Shelter. (2018) *320,000 people in Britain are now homeless, as numbers keep rising*. Retrieved 16th May 2020 from

Gypsy, Roma and Traveller communities	58,000	Figure for England and Wales from 2011 census. ¹⁰
Sex workers	72,800	UK estimate. Defining the scope of sex work makes it challenging to establish the number of people who attribute sex work as their main source of income ¹¹
People recently released from prison	57 ¹²	This is the number that have been released since the start of the COVID-19 pandemic, under the Early Temporary Release Scheme. In December 2019 82,771 people were in prison or on authorised absence in the UK. ¹³

https://england.shelter.org.uk/media/press_releases/articles/320,000_people_in_britain_are_now_homeless,_as_numbers_keep_rising

¹⁰ Cromarty H.(2019) *Gypsies and Travellers, Briefing Paper*. Retrieved 10th May 2020 from <https://commonslibrary.parliament.uk/research-briefings/cbp-8083/>

¹¹UCL Institute of Health Equity. (2014) A Review of the Literature on Sex Workers and Social Exclusion Retrieved 11th May 2020 from

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/303927/A_Review_of_the_Literature_on_sex_workers_and_social_exclusion.pdf

¹² The Guardian. (2020) *Almost 2,000 tags bought for UK Covid-19 prisoner releases remain unused*. Retrieved 13th May 2020 from <https://www.theguardian.com/world/2020/may/15/only-55-of-2000-tags-bought-for-uk-covid-19-prisoner-release-used>

¹³GOV.UK. (2020). Prison population figures: 2019. Retrieved 5th May 2020 from <https://www.gov.uk/government/statistics/prison-population-figures-2019>

3.3 Administrative and legislative changes as a result of COVID-19

There have been numerous administrative and legislative changes that have occurred as a result of COVID-19, including a package of financial measures to support public services, individuals and businesses affected by COVID-19. This includes a £500 million Hardship Fund, so that local authorities can provide council tax relief and other financial support to the most vulnerable people and households in their area.¹⁴

The COVID-19 pandemic also necessitated alterations to usual health service provision to reduce pressure on NHS services and limit the spread of the virus. On the 17 March 2020 providers were instructed by NHSE and NHSI to:

- postpone all non-urgent elective operations from the 17 April for 12 weeks
- roll out remote consultations using video, telephone, email and text messaging services for urgent GP, diagnostic or outpatient appointments and, as soon as possible, for important routine activity;
- limit face to face appointments to only when absolutely necessary¹⁵

Further details of the changes relevant to the selected groups are below.

People within the UK immigration system

Changes to Asylum Processes

There have been multiple administrative changes to the asylum process as a result of COVID-19, including suspension of weekly Home Office reporting, a move to postal submission of evidence cases and conducting legal hearings and tribunals remotely¹⁶. Whilst initial screening interviews are still being undertaken at 6 locations across the UK, face-to-face substantive interviews to progress people's claims have been postponed.

Once people have been granted refugee status, they are permitted to stay in Home Office accommodation and their financial support payments will continue until they are in receipt

¹⁴ Ministry for Housing Community and Local Government HCLG. (2020). *COVID-19 – MITIGATING IMPACTS ON GYPSY & TRAVELLER COMMUNITIES*. Retrieved 12th May 2020 from [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882564/COVID-19 - mitigating impacts on gypsy traveller communities.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882564/COVID-19_-_mitigating_impacts_on_gypsy_traveller_communities.pdf)

¹⁵ NHSE. (2020). Retrieved 4th May 2020 from <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf>

¹⁶ Refugee Council (2020). *Changes to Asylum & Resettlement policy and practice in response to Covid-19*. Retrieved 4th May from <https://www.refugeecouncil.org.uk/latest/news/changes-to-home-office-asylum-resettlement-policy-and-practice-in-response-to-covid-19/>

of universal credit. During the pandemic, those who have exhausted their appeal rights will be transferred onto section 4 support, consisting of accommodation and £35.39 per week via a payment card.

People in immigration detention

Since the onset of the COVID-19 outbreak, the number of people held in immigration removal centres has reduced from 1225 (1st January 2020) to 368, with a further 340 people detained in prisons under immigration powers. The first-tier tribunal continues to grant bail to immigration detainees on the grounds that they cannot be returned to their country of origin during the outbreak, rendering their incarceration unlawful. The Home Office has committed to urgently review the cases of every person currently held in immigration detention and have stopped the new detentions of people who would in normal circumstances be facing removal to one of the 49 countries to which removals are not currently taking place because of COVID-19 travel restrictions.^{17 18}

Access to healthcare

Regulations came into force on 29 January to add Coronavirus (COVID-19) to Schedule 1 of the NHS (Charges to Overseas Visitors) Regulations. This means, as for any other infectious disease in Schedule 1, there can be no charge made to an overseas visitor for the diagnosis, or, if positive, treatment, of coronavirus. No charge applies to a diagnostic test even if the result is negative. No charge can apply to any treatment provided for suspected COVID-19 up to the point that it is negatively diagnosed. This exemption does not automatically cover related conditions and presentations, such as paediatric multisystem inflammatory syndrome.

Gypsy, Roma and Travellers

Whilst some Local Authorities will direct a proportion of their allocation of the Hardship Fund to support Gypsy Roma and Traveller communities, there is no direct obligation for them to do so.

On 27th March 2020, the Department for Housing, Communities and Local Authorities wrote to caravan site owners and managers, instructing them to allow people including members of the Gypsy, Roma and Traveller communities to remain if they would otherwise be homeless.

¹⁷ The Guardian. (2020). *Home Office accused of pressuring judiciary over immigration decisions*. Retrieved 5th May 2020 from <https://www.theguardian.com/politics/2020/may/06/home-office-accused-of-pressuring-judiciary-over-immigration-decisions>

¹⁸ Right to Remain. (2020) *Changes to the asylum and immigration process due to Covid-19*. Retrieved 4th May 2020 from <https://righttoremain.org.uk/changes-to-the-asylum-process-due-to-covid-19/#detention>

Gypsy, Traveller and Liveaboard Boater, park home communities are listed in the Local Government Association *Protecting vulnerable people during the COVID-19 outbreak* briefing for councils as a group 'who may suffer from reduction of usual services'.¹⁹

Sex workers

Sex workers are not identified as a group with support needs in the Local Government Association *Protecting vulnerable people during the COVID-19 outbreak* guidance. Sex work is criminalised in the UK and remains so in the context of the COVID-19 outbreak. This means that sex workers are unable to access the support, payment, and protections available to others who experience a loss of income currently.

People experiencing homelessness

Government has raised the Local Housing Allowance rate to the bottom 30th percentile of local rents and put a temporary halt on evictions, in an effort to prevent new cases of homelessness and help local authorities respond to the needs of people currently experiencing homelessness.

The Local Government Association *Protecting vulnerable people during the COVID-19 outbreak* guidance identifies 'People who are homeless – in particular people sleeping rough, in shelters or hostels, and people who are being discharged from hospital or released from prison who may otherwise be homeless' as having a continued or new need for support.

'*Everyone In*': In response to COVID-19, the Government launched the *Everyone In* scheme, whereby Local Authorities were required to house rough sleepers in hotels or emergency accommodation. They also announced £3.2 million in funding for local authorities to protect those who are homeless.²⁰ In London hotels alone, roughly 1,200 people have been housed across 14 hotels and 3 staging posts. They have been split into staging posts for people with more chaotic lives, people with COVID symptoms, people who are medically vulnerable and people who are not medically vulnerable. Some people remain street homeless, mostly where they have declined support, or where they have been made street homeless recently as a result of COVID-19.

¹⁹ Local Government Association. (2020) *Protecting vulnerable people during the COVID-19 outbreak*, A briefing for councils. Retrieved 14th May 2020 from https://www.local.gov.uk/sites/default/files/documents/COVID-19_vulnerable%20people%20briefing%20updated.pdf

²⁰ Ministry for Housing Communities and Local Government. (2020) Retrieved 1st May from <https://www.parliament.uk/business/committees/committees-a-z/commons-select/housing-communities-and-local-government-committee/news/covid-19-homelessness-rented-sector-inquiry-launched-19-21/>

Recently Released Prisoners

In the context of the COVID-19 pandemic, the Government announced the End of Custody Temporary Release Scheme (ECTRS) to enable risk-assessed prisoners within two months of their release date to be temporarily released from custody as part of the national approach to managing public services, from the 7th of April 2020.²¹ The government has pledged to release 4,000 prisoners to alleviate the risk of COVID-19 transmission. As of 12th May, 57 prisoners have reportedly been released via the scheme²². A Government briefing paper dated 24th April stated that the total UK prison population has fallen by over 2,400 between 28th February and the 17th April, a reduction which can likely be attributed to a reduction in new prison admissions.

²¹Ministry of Justice, HM Prison and Probation Service. (2020) Retrieved 13th May 2020 from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881061/end-custody-temporary-release.pdfhttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881061/end-custody-temporary-release.pdf

²² The Guardian. 2020. *Almost 2,000 tags bought for UK Covid-19 prisoner releases remain unused*. Retrieved 13th May 2020 from <https://www.theguardian.com/world/2020/may/15/only-55-of-2000-tags-bought-for-uk-covid-19-prisoner-release-used>

4. PARTICIPANTS

In total 67 participants contributed to the assessment, through either an interview, focus group, testimonial or survey response.

4.1 Interview and Focus Group participants

28 interviews and 3 focus group discussions were conducted. 3 testimonials were submitted. In total, 45 participants were involved in this arm of data collection. Experiences of all of the selected groups were captured in interviews or focus groups however some groups did not have EBE representation.

EBEs

21 participants had lived experience associated with one of our selected groups. All EBE participants were aged over 18 years, 13 (62%) were female, 15 (71%) stated they were from a BAME group. The ethnicity of 4 participants is unknown. The following list details which groups the participants had current or previous lived experience of:

- People Seeking Asylum: 3
- People Refused Asylum: 1
- People with new Refugee Status: 2
- Gypsy, Roma and Traveller Community: 3
- Sex workers: 3
- People experiencing homelessness: 8
- Survivor of Modern Slavery: 1

Stakeholders

Participating stakeholders represented 20 organisations both from non-government and statutory services (see table below for details of these organisations). 4 stakeholders participated as individuals not representing organisations including 3 GPs and 1 academic. Geographically stakeholders were based in London, Leeds, Leicester, Birmingham, Bradford, Brighton, Darlington and Manchester, although several NGO participants represent organisations with a national remit.

Table 3: Description of stakeholder organisations that participated

<u>Organisation</u>	<u>Brief Description</u>
Bail for Immigration Detainees	Legal advice and representation to migrants detained in removal centres and prisons
Basis Yorkshire	Information, safety and support for female and transgender women working in the sex industry
Bevan Healthcare	General practise service designed to meet the needs of people who are homeless or in unstable accommodation, refugees or people seeking asylum.
British Red Cross	Humanitarian support in times of crisis
Doctors of the World	Part of the Medecins du Monde international network, an independent humanitarian movement.
Detention Action	Support people in immigration detention and campaign for immigration reform
English Collective of Prostitutes	An organisation of sex workers. Campaign for the decriminalisation of prostitution, for sex workers' rights and safety and for resources to enable people to get out of prostitution if they want to.
Friends Families and Travellers	Work on behalf of all Gypsies and Travellers. Provide advice and consultancy, promote health and wellbeing, work on research and policy and deliver training.
Homeless Health Exchange	Primary care assessments, nursing care and treatment for people who are homeless in Birmingham.
Leeds GATE	Leeds Gypsy & Traveller Exchange is a grassroots organisation focusing on community activism and social action
Maternity Action	Charity committed to ending inequality and improving the health and wellbeing of pregnant women, partners and young children
National Federation of Gypsy Liaison Groups	Promote the social inclusion of Gypsy, Roma and Traveller groups
Pathway	Homeless healthcare charity, helping the NHS to create hospital teams to support homeless patients
Refugee Action	Support and advice for refugee and asylum seekers
Refugee Women Connect	Outreach and drop in services for asylum seeking and refugee women
Say It Loud Club	Support and advocacy for LGBT+ asylum seekers in the UK
Southwark Travellers Action Group	Community organisation for Gypsies and Travellers based in Southwark
X: Talk: The Breakfast Club	Sex worker led workers co-operative. Provision of language classes, campaigning and advocacy for rights of sex workers.
Through The Gate	Supporting prisoners on their release from prison
Unseen	Charity providing safe houses for the survivors of modern slavery
Voices of Domestic Workers	Grassroots organisation. A support network and campaign organisation for migrant domestic workers

Survey respondents

22 people responded to the short qualitative survey, 20 of these respondents responded to both questions. The participants represented a range of sectors and organisations detailed below:

- Charity/NGO: 9
- Local Authority: 6
- Healthcare Professional (NHS): 4
- Local Healthwatch: 1
- Asylum Support: 1
- Welsh Government: 1

5. FINDINGS: CHALLENGES WITH INFORMATION AND GUIDANCE FOR COVID-19

Government issued advice and guidance has been the primary source of information for actions individuals can take to reduce transmission of the virus and their risk of infection. Published guidance relevant to the general public covers: physical distancing; self-isolation; the protection of the extremely vulnerable; and the management of symptoms. As the pandemic evolves and new evidence becomes available, there is a continuing need to update guidance. A large volume of this guidance is published and updated online, with social media, television and newspapers providing additional dissemination outlets to the general public.

In order to reduce risk of becoming infected with COVID-19 and protect themselves and their family's people must be able to:

- Access information and guidance in a timely manner and understand it
- Be able to follow guidance

5.1 Barriers to accessing information and guidance

Interviewees described substantial barriers which prevented people in excluded groups from getting the right information and guidance in a timely manner *to know how to protect themselves from COVID-19*.

BOX 1: Barriers to accessing information and guidance

People in excluded groups are often unable to access online information due to:

- Inability to pay for access to broadband or mobile data
- Lack of access to technology including broadband, smartphone, computers, tablets and televisions
- Lack of knowledge and digital skills to be able to access information via websites and social media.

Guidance is written in language that is often not understandable

- At the start of the pandemic, guidance was generally only published in English language, which is not the first language of many in excluded groups. There are delays in updating translated guidance.
- The language used in guidance is often not understandable for people in excluded groups with low literacy levels

Guidance is not targeted at socially excluded groups

- There was a notable absence or delay in developing targeted information for excluded groups

Guidance often does not reach excluded groups

- Excluded groups rely on different channels of communication when compared to the general public and these channels have not been used effectively by those responsible for disseminating guidance
- There have been delays in sharing information and guidance via expected channels

Support services and networks which would normally help are closed

- Many face to face and outreach support services for vulnerable excluded groups have been closed
- Visits to immigration centres and prisons have been stopped, preventing the sharing of information
- Social networks and meetings that people rely on to share information are no longer possible

IMPLICATIONS

People in excluded groups may not know what they should be doing to protect themselves from COVID-19

The development of guidance can only be effective as a public health measure for these socially excluded groups if they are:

- accessible to people without access to telephones, television and the internet
- accessible to people in whom English is not their first language or have literacy and comprehension difficulties
- disseminated in a timely manner through the channels used by these groups
- accompanied by efforts to build trust and belief

5.1.1 Digital exclusion

Digital exclusion was a key barrier identified by participants across all groups. Where access to the internet was restricted, access to the online guidance and online symptom checkers were limited. This digital exclusion was present for three main reasons:

- Lack of financial means to pay for access to broadband or mobile data
- Lack of access to the right technology
- Lack of digital skills.

Say It Loud Club reported to us that half of the people (30/60) who accessed their services during lockdown said that they faced digital barriers to accessing government information about COVID-19.

Lack of financial means

Many of the people from these groups are living in situations of very low income, which means a choice often has to be made between purchasing data or other basic essentials. The community and voluntary sector (CVS) organisations that would usually support people with SIM cards with prepaid mobile data are reportedly no longer able to offer these face-to-face services. A staff member at Doctors of the World commented: *“The first thing that happened was that these support groups closed, and people lost their access to data. This has become a more urgent need than food.”*

Lack of access to the right technology

Interviewees reported that asylum seekers living in initial accommodation do not have access to broadband internet. People from Gypsy, Roma and Traveller communities living on traveller sites, unauthorised encampments or roadsides have poor or unstable access to the internet with some relying on a single Wi-Fi router for an entire traveller site.

Immigration detainees are not allowed smartphones, and computer rooms are only accessible during certain hours, and some websites, including NGO sites, are blocked. Prisoners have no access to the internet. People held in confinement are reliant on prison or immigration removal centre staff members to access information and guidance. A staff member at Bail for Immigration Detainees commented: *“It’s about accessing information, they see staff members walking around in Hazmat suits, and then they don’t know what’s happening, does someone have the virus? So this causes more anxiety and panic.”*

No access to television and telephones were also identified as additional barriers to receiving information.

Lack of digital skills

Publishing guidance online excludes those without digital literacy. Stakeholders reported that there are lower levels of digital literacy in particular groups, such as people from Gypsy, Roma and Traveller communities²³. As well as limiting ability to follow the guidance, this deepens actual and perceived exclusion from this information. Interviewees reported that many are instead using their family and peer networks to share this information.

“I am really aware a lot of people we are trying to get in contact with are older and vulnerable and don’t have computers, and they won’t see Facebook. It’s very difficult to know how to get information out to them” Manager of Southwark Travellers Action Group

5.1.2 Language and literacy skills

The government and NHS guidance has predominantly been published in English, which can be inaccessible to people within the immigration system or people whose first language is not English. While some translations of the guidance have been published, the number of languages has been limited, and updates to these translations have lagged behind the English guidance. Doctors of the World, alongside the British Red Cross and several other partners have translated the NHS guidance into 60 languages, including some audio versions. This has reportedly increased access to the key health-related guidance necessary for individuals, and supported organisations and frontline workers to disseminate the guidance. Nonetheless, there is still a time lag between the publishing of English and translated guidance, and these translations do not capture the breadth of guidance being produced by the government at speed.

We were told that several people within our included groups do not have the literacy skills to read and/or comprehend the guidance written in their own languages. People from Gypsy, Roma and Traveller communities and people experiencing homelessness often have lower levels of literacy than the general population, so many cannot access written guidance. Easy-read versions and videos of the main pieces of guidance have been produced in English. However, accompanying audio or video guides are not available for all communications. We heard an example where GPs were sending letters to people informing them they were clinically extremely vulnerable to COVID-19, despite these people being recorded as without literacy on the GP system. Those without the social support structures to help them understand the guidance have therefore been excluded from this information.

“Lots of people feel that without... [communication provided by local CVS organisation] we would feel forgotten. Many people can’t read or write or go online.” Member of the Gypsy and Traveller Community

²³ Friends, Families & Travellers. (2018) *Digital Exclusion in Gypsy and Traveller communities in the United Kingdom*. Retrieved 7 May 2020 from <https://www.gypsy-traveller.org/wp-content/uploads/2018/09/Digital-Inclusion-in-Gypsy-and-Traveller-communities-FINAL-1.pdf>

5.1.3 Insufficient or delayed inclusive guidance

The lack of practical guidance that recognises the diverse circumstances in which people live, especially marginalised groups, has been noted by people from these groups as well as those working with them. A staff member at Doctors of the World noted: *“And that’s concerning, you know, it’s clear how much the public health system has been hollowed out – to not be able to respond to diversity of needs in a pandemic situation is appalling.”*

An asylum seeker commented on this feeling of exclusion: *“As asylum seekers the first thing we felt was left out by the government. I know the government is facing crazy moments, but being a leader of a country facing coronavirus it’s not just about thinking about citizens and residents, it’s about all human beings that live in the UK.”*

The delay in issuing guidance for Gypsy, Roma and Traveller communities living in sites with shared facilities created uncertainty for people in those communities, as described by a staff member of Friends, Families and Travellers: *For a lot of people we work with, when it says ‘you can eat your meal in a separate room, or use separate toilets’, these aren’t options that are available to a lot of our service users. And it really showed the inequalities between the people who are making the policy and the people who have to follow that policy... It just felt like reading that to people who don’t have any of those options, it just created a lot more worry. It says in the guidance, ‘if you can’t do these things, just do your best’ - and it feels outside people’s control.”*

5.1.4 Delays in dissemination of guidance

People working with asylum seekers reported significant delays in the dissemination, through the appropriate channels, of the initial guidance on staying at home and social distancing to asylum seekers. A case worker from an NGO reported: *“They didn’t receive any information. They should have received information from the Home Office or their housing provider, but they didn’t”.*

Many reported that people within the immigration system were not told about the changes in reporting requirements for immigration bail and asylum applications. Say it Loud Club reported to us that fifty percent of people accessing support through their services said that they had continued travelling to report to immigration centres until receiving updates from the Home Office weeks later.

“Many thought these stay at home guidelines didn’t apply to them because they were supposed to go and report to an immigration centre. Others had interviews in the pipeline. Others were supposed to go to Liverpool to make further submissions for their cases. So it took time before people started sending messages to asylum seekers informing them not to report or come to interview. But that caused more fear and anxiety because people were confused. What if someone checks on their reporting calendar and sees they were supposed

to report them? Eventually they started sending updates, but it should have been done sooner.” Director of Say it Loud Club.

5.1.5 Lack of access to usual sources of support

Experts by experience and stakeholders reported that there has been a reduction in the availability of other support services and social networks through which people can access information related to the COVID-19 pandemic. This is particularly relevant for those without access to the internet and telephones, or who have complex lives or mental health problems. Many rely on face-to-face and outreach services that have had to be reduced or stopped during lockdown. This also reduces access to service offers during the pandemic, such as the offer of accommodation for homeless street sex workers.

“And this [the organisation] is their only source of information that they have and that they trust. They don’t get much mainstream information from government or NHS services.” Director, Say It Loud Club

“So in the local authorities where there’s a really positive Gypsy & Traveller liaison officer, they’ve been contacting us for leaflets... by the stage it could be something we actually could do, everything went into lockdown and most places that were providing outreach services weren’t functioning anymore.” Staff member of Friends, Families & Travellers

Visitation services for immigration detainees and prisoners have also been stopped. In the case of immigration detainees, visitation suspension has also restricted their access to mobile phones and sim cards that would otherwise allow them to communicate with their social networks outside the centre. According to stakeholders, this is significantly preventing their access to direct information about what is happening outside.

Despite these barriers, many organisations are taking steps to help their service users receive as much information as possible and support those in more vulnerable circumstances through alternative means.

5.2 Barriers to following information and guidance

Interviewees described substantial barriers which prevented people in excluded groups following Government and NHS guidance on staying at home, physical distancing, self-isolation and shielding for extremely vulnerable people. Some barriers are a consequence of living circumstances and destitution, others are psychosocial, but most are a combination of these issues and are rooted in long-standing experiences of social exclusion. These barriers impaired people’s ability to protect themselves from COVID-19.

Findings related to this are further explained in this section. Additional barriers that prevent people from following shielding guidance and guidance on healthcare seeking are covered in sections 6 and 7, respectively

BOX 2: BARRIERS TO FOLLOWING INFORMATION AND GUIDANCE

Accommodation related barriers that make guidance very difficult to follow. This is due to the circumstances that people in excluded groups find themselves living in, for example:

- Shared accommodation with people who are not friends or family
- Accommodation with communal facilities such as bathrooms and kitchens
- Overcrowded accommodation, including limited space for storing items
- Places with no access to water and sanitation facilities, or fuel and gas. This includes people who are experiencing street homelessness
- People living with others often have no or limited control over behaviour of others that they live with, which presents risk to them
Domestic workers, people experiencing modern slavery and people in prisons or immigration removal centres often do not have the autonomy to be able to protect themselves by changing their circumstances

Need to go outside frequently to obtain income, meet basic needs or manage addiction

- On low incomes, it is often not possible to buy in bulk or store food so there is a need to shop regularly for small amounts
- People in excluded groups often are not able to access state benefits and need to leave home to obtain income to meet basic needs such as buying food
- For sex workers their work is often their only income; others rely on begging
For those with drug or alcohol addictions, going out to access their addictive substances or prescriptions is necessary to avoid withdrawal

Lack of belief in information about COVID-19

- Some people in these excluded groups reported that other people in their community or their accommodation did not believe that COVID-19 was real
- Belief in COVID-19 myths spread rapidly, particularly within groups who have low levels of trust in authority

IMPLICATIONS

The circumstances that people in excluded groups often find themselves mean that even if they know how to, they are not able to protect themselves from coming into contact with COVID-19

For people to be able to follow COVID-19 guidance, it must:

- Consider the specific life circumstances of people facing vulnerable circumstances
- Include adequate provisions and recommendations for a range of life circumstances
- Be sufficiently prescriptive so that people with responsibility have clear instructions of how to implement guidance
- Be understandable and feasible to implement

5.2.1 Accommodation related barriers

Interviewees identified barriers related to particular living situations:

- Shared accommodation
- Traveller sites, unauthorised roadside encampments, canal boats
- Street homelessness
- Confinement

These are explored in further detail below.

Shared Accommodation

Shared accommodation includes: the initial accommodation of asylum seekers; the large shared accommodation used for unaccompanied asylum seeking children; or shared housing used by people who are survivors of modern slavery, are undocumented, are experiencing homelessness; or living in destitution.

Interviewees reported that communal living and eating areas, and shared bathroom facilities make physical distancing and self-isolation difficult. Overcrowding in initial asylum accommodation, caused by the suspension of dispersal, was raised as a key issue. Cleanliness is also reportedly poor in these shared accommodations, areas with shared facilities and immigration detention centres. Pregnant women and people with medical conditions feel particularly unable to follow the recommended guidance.

Half of the people using Say It Loud Club services during lockdown reported problems with living in shared accommodation that have worsened during the pandemic.

“How is it possible to self-isolate in a shared house with three mums and 6 children where you share a toilet and bathroom? And if we have to self-isolate there is no way of us getting food. They pay us weekly, it’s not like a bulk money. The money we have is hardly enough to eat for the whole week. And there is no way we can take help from any other person. I haven’t had credit on my phone for 4 to 5 days. No calls are possible if you run out of credit. You have to wait for people to call you.” Newly recognised refugee

People also reported feeling a lack of control about the actions of others they live with: *“One of my flat mates, she is the kind of person that believes there is no coronavirus and the other one extremely believes the coronavirus is caused by the devil. The one that believes there is no coronavirus, she invites some of her friends over and you can’t stop her. When people come in I just have to make sure my daughter is in the room and make sure she washes her hands every time. I take a long time to explain to this flatmate, I tell her it is real and people are dying. And the one that believes the coronavirus is even in the air, is saying that even if you open the door she is screaming that coronavirus is in the air [sic]. It is different to what I believe, it is difficult.”* Newly recognised refugee

During the early stages of the pandemic some initial accommodation providers reportedly delivered advice that was in conflict with the government advice e.g. advising people to spend more time outside if they felt unable to physically distance indoors. Some asylum seekers reported feeling unsafe and feeling that staff were being given more protection than residents. Staff in initial accommodation carried out risk assessments to identify people who would be classified as vulnerable or extremely vulnerable. However, healthcare staff reported that some asylum seekers living in initial accommodation had communicated that they felt this happened too slowly.

Multi-generational households, which are more common within Gypsy, Roma and Traveller communities and other BAME groups and migrant communities, were identified as being a challenge for older people needing to physically distance. They can also be a source of support.

Living in Traveller sites, unauthorised roadside encampments or canal boats

People from Gypsy, Roma and Traveller and Liveaboard Boater communities experience different challenges depending on where they are located. Findings from the interviews are discussed below. Self-organisation within these communities to support one another and manage the shielding of the extremely vulnerable has been an important protective factor identified in interviews.

There is a general lack of living space within caravans, trailers and boats for adequate physical distancing and self-isolation. Overcrowding has also increased as people try to stay in one place. People's need to access basic water and sanitation; rubbish disposal and top up electricity can present problems for physical distancing or self-isolation once symptomatic. The shortage of space within homes for storing supplies has increased the likelihood of breaking self-isolation to go shopping, particularly if some of the areas where people are living are deemed inaccessible by online shopping delivery services.

On Traveller sites, kitchens and bathrooms are often communal facilities, which are close to one another. To abide by the guidance, these facilities require regular cleaning between residents, which is reportedly dependent on the site manager to arrange. The lack of running water in some sites is a barrier to following hand washing advice. People also need to ensure they have access to fuel and gas to cook and heat their homes, but these are not included in the basic supplies offered to those who are shielding.

“How can you self-isolate in a small trailer? And you may be sharing toilet facilities. You can have 18 families accessing one toilet on transit sites. And even the structure of some sites, especially transit sites, things are close together. And it's trying to get people to understand you can't just nip into your neighbours like you normally do. It's getting the message across. It's easier with small family sites. Private or large council sites are much harder.” Policy Officer from National Federation of Gypsy Liaison Groups

People living roadside are less able to access their basic needs, as the usual facilities they would rely on for water and sanitation are now closed. Without an address, people who should be shielding in these groups are unable to access external support. Some Local Authorities have also reportedly been evicting people on unauthorised encampments, which mean that people are having to travel to find another site. This has not been the case in all local authorities; for example, some have reinstated negotiated stopping sites that allow people to stay in a suitable area in order to access basic services.

For people living in canal boats, self-isolation or shielding whilst members of the public are using the canal paths is challenging. This has led to some people moving to more isolated spots, which are much harder to reach by support services. The support from waterways organisations has been important.

Street homelessness

The government's drive to move people experiencing homelessness, regardless of their recourse to public funds status, into hotel accommodation has been well received by those we interviewed. Nonetheless, there are still people living on the streets for a number of reasons including mental health problems; pet ownership; fear of living inside after years of being outside; and becoming newly homeless during the pandemic. People sleeping on the street are much less able to abide by the guidance on physical distancing and handwashing, without access to water and sanitation facilities.

Confinement

Situations of confinement include prison, immigration detainment, and modern slavery. Within prisons and immigration removal centres, managing physical distancing within communal areas is challenging. Stakeholders reported that people are still sharing small cells/rooms and are being held in unsanitary conditions. The cleaning is often done by people who are imprisoned or detained, without the necessary training. Information provision to those who are confined has also been poor. An organisation working with immigration detainees reported that detainees have not been given soap for handwashing. People are being moved from prisons, with higher rates of COVID-19 infections, into immigration removal centres, leading to concern that people in the latter are being exposed to unnecessary risk.

"People are very anxious. And people are told to socially distance but obviously in prison, you share cells with other people who move around so you actually can't socially distance, so they are really scared." Employee from Bail for Immigration Detainees

Self-isolation for people with symptoms has also not been enabled within immigration removal centres. Detention Action described a particularly concerning report of a detainee who had, early in the pandemic, reported concerns to healthcare staff about having a fever and cough. He was reportedly denied medication and was not self-isolated as he was not felt to have COVID-19, despite never having had a test. Detention Action understands that after

his later release from detention, he died in the community within 24 hours. As things stand, there are hundreds who are being held under immigration detention powers despite there being no prospect of removal to their countries of origin.

Domestic workers living within the homes of their employers are at risk of exploitation and reduced access to information, and we heard about many such cases currently happening. The practice of social distancing and isolation are often beyond their control. Their employers are their source of income and shelter, and some work without sufficient pay or food. There have been reports of people being made to work when their employer is unwell or having to work in houses where their employers are not following the government guidance. This is likely to be the similar situation for others who are victims of modern slavery or trafficking.

“We have a member whose employer came home with fever. In morning she had to change the bed of her employer. She was very scared, she said ‘I don’t have mask, I didn’t wear gloves to touch beddings and put [them] in washing machine. I tried to talk to employer to say these concerns’ – but there is nothing she can do because she is in the household. Employers don’t think that the domestic workers need to look after themselves.” Founding member of The Voice of Domestic Workers

5.2.2 Need to go outside

Accessing food

For people living in destitution or on a very low income, we were told about many difficulties managing access to food during the pandemic. Maintaining a stock of food to allow less regular shopping or isolation is not possible due to space and budget constraints. In order to manage shopping on their tight budgets, people often need to go to different areas to source cheaper items and go more frequently, thus exposing themselves to greater risk of exposure to the virus. Such travel is usually on public, rather than private, transport. Relying on others for support is also less possible. One asylum seeker noted that if he needs to self-isolate, others would not be able to do the shopping on his behalf ‘as wisely’ as he does. Online shopping is out of reach for people receiving financial support through the preloaded payment card.

“How as an asylum seeker can you avoid going out? We don’t even have a bank account to do the shopping online. The bank card we have, it is not permitted to use online. And we don’t have enough money. And sometimes we don’t buy in one place, we buy in different places, so it’s really complicated.” Asylum seeker

Many people from the groups of study already rely on food banks but since the pandemic there has been an increase in people using this service. One asylum seeker reported that he and other asylum seekers feel less able to access universal food banks during this time, for fear of discrimination: *“A lot of food banks can’t help too because asylum seekers are scared*

to go when other people are also there - don't want to be looked at or stared at. Seen as different, not from the country, don't want to be seen as taking other people's food."

Addiction, sex work & 'street begging'

For some, the risk of COVID-19 is overshadowed by other risks they face; of having no money; or of experiencing withdrawal from their drug or alcohol addictions. Interviewees reported several such examples.

Street sex workers without access to government support have reported continuing to work in order to obtain an income, therefore putting themselves at risk of COVID-19. One sex worker said: *"Those who aren't getting [or] able to get state help are facing criminalisation for working. Street based workers are facing a near impossible situation."*

Similarly, reliance on the general public for money as a means of financial survival continues during the pandemic, despite the increasing personal risk of COVID-19. This includes going into confined spaces, such as the London underground, and spending longer hours street begging due to the lower footfall.

Earning money to fund substances and going out to access substances are necessary activities for people experiencing addiction and are therefore barriers to following the physical distancing and self-isolation advice. This may be worsened by the reduction in drug and alcohol support services.

5.2.3 Lack of belief in information about COVID-19

There were also reports of people within these groups denying the presence of symptoms, or believing that COVID-19 doesn't exist, despite those working with them being certain that they had it. A high volume of fake stories about the existence and origins of COVID-19 was noted to be circulating within the Gypsy, Roma and Traveller communities. The perpetuation of such myths can be worsened in communities where the trust in government and authorities is much lower, or where there are pre-existing gaps in access to accurate information.

"Trust being a big one [issue] - lack of trust in the messaging sometimes from healthcare services. And we're seeing that really come to life through coronavirus. We're seeing significant amounts of fake news spreading on social media... I've been quite shocked actually about the high levels of it." Staff member of Friends, Families & Travellers

Disbelief in the existence of COVID-19 or denial of symptoms make it less likely guidance targeted at reducing transmission of and infection with the virus will be adhered to.

6. FINDINGS: UNDERLYING HEALTH CONDITIONS & COVID-19

Certain underlying health conditions are associated with an increased risk of severe illness due to COVID-19. Public Health England have produced a list of conditions that are likely to make individuals 'clinically vulnerable' or 'extremely clinically vulnerable'. People identified as extremely clinical vulnerable should 'shield', i.e. avoid all face-to-face contact. This guidance is described further in Appendix 2.

Interviewees described additional challenges experienced by people in vulnerable circumstances, with respect to these underlying health conditions. This included being:

- more likely to have these conditions
- less likely to know they have these conditions
- less likely to have support with avoiding face-to-face contact with others (shielding)

BOX 3: Underlying health conditions & COVID-19

People in some excluded groups may be **more likely to have medical conditions which make them vulnerable** to developing severe illness due to COVID-19. This includes conditions which make people 'clinically extremely vulnerable'.

Many people in excluded groups **do not know that they have medical conditions and should be shielding**. This is due to:

- Poor access to healthcare (e.g. not being registered with a GP) to get a diagnosis
- Fear of going to healthcare to be diagnosed and treated for their medical condition

People in excluded groups **may not have the support needed for shielding** because: They believe they are ineligible for this support or encounter barriers to registration

- The support provided is not tailored to their needs

IMPLICATIONS

People who are socially excluded are more likely to become severely unwell due to underlying health conditions, which they may be unaware of. Without shielding, clinically vulnerable people in excluded groups are more likely to become severely unwell from COVID-19.

People with underlying health conditions from socially excluded groups cannot effectively protect themselves from severe illness due to COVID-19, unless they are:

- included within the health system so that they are diagnosed and properly managed
- identified as being clinically vulnerable through risk assessments
- offered support with shielding that is accessible and tailored to their needs

6.1 Likelihood of having underlying health conditions

While we do not have estimates of what proportion of all the chosen groups would be classified as clinically vulnerable or extremely clinically vulnerable, we know that people within our chosen groups have high rates of physical health problems, including many of those listed by PHE²⁴²⁵²⁶²⁷²⁸. Appendix 1 includes some background health data about the main conditions affecting the socially excluded groups included in this report.

Note that the risk of poorer health outcomes is clearer for some groups, e.g. people experiencing homelessness, than it is for others. Nevertheless, people in the most vulnerable circumstances are generally more likely to experience poor health, have poorer management of long-term conditions and experience barriers to accessing and utilising health services (discussed in section 8). All of these factors are likely to worsen their overall susceptibility to more severe illness from COVID-19.

6.2 Identification of underlying health conditions

Identification of clinical vulnerability relies on having a diagnosis of the conditions mentioned above. As a result of exclusion from health services, some people within our chosen groups do not know that they have the relevant conditions or are not known to the health system for those conditions.

²⁴ Aldridge, R et al. (2019). *Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England*. Retrieved 13th May 2020 from <https://wellcomeopenresearch.org/articles/4-49>

²⁵ BMA. (2019) *BMA refugee and asylum seeker health resource*. Retrieved 11th May 2020 from <https://www.bma.org.uk/media/1838/bma-refugee-and-asylum-seeker-health-resource-june-19.pdf>

²⁶ UCL Institute of Health Equity. (2014)

²⁷ House of Commons Health and Social Care Committee. (2018) *Prison health*. Retrieved 9th May 2020 from <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf>

²⁸ House of Commons Health and Social Care Committee. (2018)

This is particularly the case for people:

- without the agency to access healthcare services, such as victims of modern slavery and trafficking
- who experience deterrents to accessing healthcare, e.g. due to irregular immigration status
- who are not being risk assessed and identified, e.g. within immigration detention

These barriers to seeking and accessing healthcare are discussed in further detail in section 3.

Without being able to identify their own clinical vulnerability, people are less likely to take additional measures to physically distance and shield as necessary. Of note, participants reported that people experiencing homelessness, who are being housed within hotels, are having health assessments to help identify existing vulnerabilities.

6.3 Support with shielding

Identification of conditions has even greater significance for those that are ‘clinically extremely vulnerable’, so that they can shield. Shielding can only be achieved with support in accessing food, required medications and other essentials.

“A cancer patient on a 5-year visitor’s visa called us because she was destitute. She had been receiving food parcels from the council, but has recently been moved by the Local Authority and is now without any food or money. She shouldn’t be leaving her home but has no friends or family.” Staff member of Doctors of the World

Doctors of the World reported receiving calls early on in the pandemic from people who should be classified as clinically extremely vulnerable but had not received a letter from the government. This resulted in those people thinking that they were ineligible for additional support with food and medicines to keep them shielded, even though they were less likely to have other sources of social support. Particularly at the start of the UK outbreak, the process of registering people for this support was complex to navigate without a letter. While it is now much clearer how to register people, this has led to delays.

Interviewees also reported that migrants with irregular immigration status are also worried about registering for this support. This is because of concerns about sharing their information and how this data will be used, and particularly whether it will be shared with the Home Office. One of the first questions asked when registering is for the person’s NHS number, which can act as a significant deterrent. By linking access to such support to government systems, this excludes people who have been systematically deterred from identifying themselves to public services, including the NHS.

Stakeholders said that some of the people they work with have not been able to register because they are not physically able to receive the support without an address. People trying

to shield in canal boats have found that, in order to shield effectively, they have to move to more isolated spots, which are in turn harder to reach by support services. In addition to food and medicines, shielding members of the Gypsy, Roma and Traveller community also require support with access to fuel, gas and water.

Informal support structures like mutual aid groups and community groups to help with shopping are being coordinated through Facebook and other online groups. This has reportedly excluded people without digital access or literacy from these sources of support.

7. FINDINGS: BARRIERS WHICH PREVENT OR DELAY PEOPLE ACCESSING HEALTHCARE FOR COVID-19

BOX 4: Barriers which prevent or delay people from recognising that they should seek healthcare for COVID-19

Lack of knowledge and awareness of COVID-19 and disbelief in its existence due to reduced access to accurate information on the virus, its symptoms and when to seek medical attention

COVID-19 is less of a priority for people in vulnerable circumstances with multiple needs- e.g. getting food is more important than thinking about their health e.g. ‘a cough’

Difficulty recognising COVID-19 on a background of poor baseline health where symptoms e.g. ‘a cough’ may frequently be present

Fear and lack of trust in health professionals, the NHS and government in particular:

- Fear of being charged for care despite the COVID-19 charging exemption
- Fear of information being shared with the Home Office

Barriers to accessing the NHS 111 telephone service for symptoms of COVID-19 due to:

- Required access to a telephone
- Language barriers
- Caller self-confidence and trust in the service

Not knowing where to go to seek healthcare for symptoms of COVID-19

- Usual “trusted” services suspended
- Additional GP registration challenges associated with the pandemic

Practical problems in reaching healthcare including:

- Inaccessibility of public transport e.g. cost, public transport routes
- No telephone access to call for an ambulance

IMPLICATIONS

People who live in vulnerable circumstances are less likely and able to access healthcare for COVID-19 illness and receive the care they require. We might therefore expect that people in the selected groups may be at greater risk of worse health outcomes from COVID-19.

People living in vulnerable circumstances are more likely to access healthcare for COVID-19 illnesses if:

- They are provided with sufficient understandable information on what services are still available to them during COVID-19 and how to access them
- They are supported to access services where there are practical barriers such as transport or digital exclusion
- All services are free at the point of access
- People are given sufficient clear, comprehensible information about NHS charging

7.1 Barriers which prevent people in excluded groups from recognising that they should seek healthcare for COVID-19

7.1.1 Lack of knowledge and awareness of COVID-19

As has already been discussed, the groups included in the study have reduced access to information about COVID-19 and as a consequence some people may not know the symptoms to look out for or when they should seek help.

“Most people who get the symptoms will just think it is the flu.” British Romani Gypsy

Additionally, for those whose baseline health is already poor it can be very difficult to identify the symptoms of COVID-19. Interviewees told us that a cough is a common symptom amongst homeless populations, street sex workers, and drug users, and as one expert by experience explained, heroin withdrawal symptoms are similar to the flu.

Across most groups included in our report there were accounts of people not believing that COVID-19 exists, as discussed in section 5. This also means they do not recognise the potential seriousness of their condition and may not seek timely medical review. While this phenomenon is not exclusive to people within the groups we examined, its likelihood is increased by reduced exposure to accurate and trusted information.

“COVID-19 is not a priority”

There are some people within the groups we studied for whom, for reasons of basic survival needs or addictions, seeking healthcare is not a priority.

“Health is not a priority for most rough sleepers. They have other things that are important to them...access to food and safety are higher priorities for them. They often need additional prompting to think about their own health and recognise COVID symptoms.” GP for Doctors of the World

7.2 Barriers which prevent or delay people in excluded groups from deciding to seek healthcare for COVID-19 symptoms

7.2.1 Fear and lack of trust in health professionals, the NHS and government

Our interviews identified fear and lack of trust to be common deterrents to accessing healthcare services across all groups. The sources of these fears are wide-ranging but many are rooted in peoples experience of marginalisation.

Many people from the included groups have a lack of trust in health professionals who they perceive to be figures of authority. Gypsy, Roma and Traveller communities, Sex Workers, and some migrant groups have been subjected to government legislation that increases their risk of criminalisation. Negative experiences with the criminal and justice system, immigration services and social care has created a distrust in public services.

These pre-existing barriers of fear and distrust play a significant role in deterring health service utilisation at a time when need is potentially greater and health services are already more complex to access. As one British Romani Gypsy said of people in her community in the case of them developing symptoms of COVID-19: *“They would have to be on their deathbeds before they would go to a GP.”*

One refused asylum seeker’s distrust ran so deep he feared he would be experimented on if he sought hospital treatment for COVID-19: *“As asylum seekers, the main fear is going to hospital... [The] NHS is trying everything they can to find a vaccine – they can try it on people as well. I’m not saying it is happening but that is the fear... I am not secure myself, they will not secure me when I am sick.”* Refused asylum seeker

7.2.2 Fear of overseas visitor charging and NHS data sharing with the Home Office

Despite diagnosis and treatment for COVID-19 being exempted from hospital charging, the NHS is still regarded as a “place of fear” for many of our identified groups. One NGO case coordinator commented: *“They are concerned they will be charged by the NHS... they would avoid unless they were really very poorly”*. People are avoiding hospitals because they are uncertain if their symptoms are a consequence of COVID-19 and if it is not they worry treatment could be chargeable. Participants feared the consequences of unpaid NHS bills, including the risk to asylum claims. Concern about NHS data sharing with the Home Office and associated possible detention and deportation was mentioned in the interviews. Hostile Environment policies have eroded trust in healthcare services to such a degree that even if the message of COVID-19 charging exemptions reaches asylum seekers and undocumented migrants, it is not sufficient reassurance for some.

“The NHS has spent 6 years sending letters to these people saying they aren’t entitled to NHS care and that they’re going to be reported to the Home Office. And that’s worked. That fear is there in these communities. And you can’t just turn that fear off now when you want people to come forward. Our patients have a very good idea that the NHS services are not for them.”
Staff member of Doctors of the World

7.3 Barriers which prevent or delay people in excluded groups from accessing healthcare for COVID-19 symptoms

7.3.1 Barriers to accessing the NHS 111 telephone service

The public are being advised to contact the NHS 111 telephone service for advice if they develop symptoms of coronavirus. Interviews revealed that many people from the groups of interest were aware of this advice. However, interviewees also told us that the practical and personal challenges that an individual may need to overcome to follow this advice meant it is not a realistic option for some people.

Contacting NHS 111 requires telephone access and sufficient proficiency in the English language to make the call. While a caller is entitled to ask the phone advisor for a translator, just getting to this point can be very difficult for someone for whom English is not their first language. A DOTW staff member who works on the DOTW telephone advice line explained: *“A lot of our population don’t have English as a first language and again that can be quite off putting for them having to pick up a phone and ring us...even though we do offer [a] translation service they may not know this and therefore are not going to be as able to access the service in that way.”*

One NGO told us of a client with complex health needs whose first language is not English who often calls 999 instead of 111 for medical support as they found they were able to access an interpreter quicker and easier using the 999 service.

Aside from the practicalities of making the phone call, confidence and trust are also necessary. As one interviewee who works for an NGO supporting women in the sex industry told us: *“The women would probably come to us first if they developed symptoms even though they probably do know to call 111. I think there are a load of reasons for this but mostly I think it is because they know when they have gone through those systems before prior to COVID, they sometimes get fobbed off, not listened to.”*

The barriers to accessing remote services are discussed in greater detail in section 8.

7.3.2 Not knowing where to go to seek healthcare

By definition, the selected groups are excluded from mainstream healthcare including a large proportion who are not registered with a GP. Interviews revealed that the suspension of walk-in services, mobile clinics and outreach services means many people from these groups no longer know where to go for healthcare should they become unwell with symptoms of COVID-19. Since the pandemic, interviewees have reported GP de-registrations as people are socially distancing or isolating away from their usual address, and refusal of new GP registrations because of the current COVID-19 crisis. This removes the option of primary care as a source of medical advice should an individual develop symptoms of COVID-19.

Each of these issues are explored in greater detail in section 8.

7.3.3 Practical problems in reaching healthcare

Suspension of mobile clinics and outreach services makes physically accessing healthcare a challenge for some people. The cost of public transport may be prohibitive to those experiencing deprivation or, as one interviewee told us, for people living at some Traveller sites and unauthorised encampments, it just is not available. A DOTW staff member told us: *“A lot of rough sleepers rely on their physical ability to do things and would usually walk to access services. But if they became unwell with COVID they would be physically too unwell to do that and again if they don’t have access to a phone then calling for an ambulance or calling for help becomes impossible to do.”*

8. FINDINGS: BARRIERS WHICH PREVENT OR DELAY PEOPLE ACCESSING HEALTH SERVICES FOR NON-COVID-19 HEALTHCARE

BOX 5: Barriers which delay or prevent people in excluded groups from accessing urgent or routine healthcare

Problems with GP registration

- GP registration has become even more challenging
- De-registration of people who are temporarily housed outside of catchment area
- Delays in transferring registration

Routine health services have closed or are operating reduced services

- Reduced face to face GP consultations
- Closure of drop-in, mobile clinics etc
- Supported access to mainstream health services suspended
- Reduced secondary care services such as outpatient appointments, surgery
- Closure of specialist services or reduced flexibility of critical support services including
- Drug and alcohol services
- Mental health services
- Children's services

Remote healthcare services are hard to access due to:

- Need for phone credit, devices, Wi-Fi, mobile data
- Language barriers

Fear and lack of trust in health professionals, the NHS or the government

- Fear of being charged for care
- Fear of information being shared with the Home Office
- Fear of catching COVID-19 in health facilities

IMPLICATIONS

People living in vulnerable circumstances are experiencing new barriers to healthcare during COVID-19, making them less able or willing to seek medical services. Delayed presentations or non-presentations to healthcare are likely to lead to poorer short and long-term health outcomes making it likely that the health inequalities already experienced by the identified groups will increase.

People living in vulnerable circumstances will continue to face access barriers unless:

- It is easy to register at GP surgeries nationwide
- Vital services offer some face-to-face service provision (i.e. primary care and drug/alcohol services)
- Services which improve access are re-opened such as drop-in and mobile clinics.
- Adjustments are made for those who cannot access remote services
- All care is free at the point of access
- People are confident that care is confidential, and information will not be shared with the Home Office
- People are given sufficient clear, comprehensible information about NHS charging

8.1 Problems with GP registration

GP registration means greater opportunities for illness prevention and early intervention for excluded population groups and decreases the likelihood that these patients resort to unscheduled or emergency care.

The groups included in this report routinely face barriers to GP registration. For example, contrary to NHSE guidance people, people are regularly denied registration by GPs because of their inability to provide a proof of address or ID documents. Multiple participants reported GP registration has become even more challenging during COVID-19. Some GPs have closed their surgeries to new registrations.

This is a particular problem for newly released prisoners, new asylum seekers, mobile groups who arrive in a new area during 'lockdown' and people experiencing homelessness who are being displaced as they are housed in hotels. Even specialist practices have insisted on paperwork for registration. As one British Romani Gypsy explained: *"If you get symptoms, first you have to find a place to stop and then find a GP that will accept you. The chances of finding those two things? You've got no chance."*

Interviews revealed that although some GP practices are maintaining registration for their temporarily displaced patients, other GPs are deregistering patients who have been temporarily housed outside their catchment areas or who are socially distancing/isolating at an alternative address. Participants informed us that de-registration from GPs during COVID-19 had led to delays in access to medications such as antidepressants. GP de-registration also disrupts continuity of care and undermines trust, creating additional access barriers to primary care. Furthermore, moving GPs takes resilience. It can be tiring and frustrating, as expressed by an EBE supported by Pathway: *"The transfer of all your files is a real pain in the ass... they say they've sent it but they haven't sent it, the new practice doesn't load it into their system, so to keep up with all your medications you have to fight all over again, you have to*

go through your history and it can be very tiring and aggravating. And to learn the ins and outs of a new surgery it can be very anxiety building.”

8.2 Routine health services have closed or are more difficult to access

Primary and secondary health care providers had to suspend or revise many of their services in accordance with NHSE and NHSI and PHE guidance. This has had a disproportionate impact on our identified groups.

“Across the board we have the potential to see massive impacts on all aspects of healthcare in the long run because of everything that has been put aside to manage COVID.” GP for Doctors of the World

8.2.1 Reduced face-to-face GP consultations

A relationship of trust is so important to the groups included in our report for all the reasons already discussed. Many excluded people rely on having face-to-face services such as GP surgeries to drop into and access help with making appointments or ordering prescriptions. Face-to-face interactions are better at promoting trust than remote consultations. A DOTW GP summed this up: *“Trust is so important. We are often dealing with very vulnerable people who already have issues with trust, sharing information and seeking help and the thing you can do is build trust and a relationship by having a conversation face to face. Now we are unable to do this and have to do most of our consultations over the phone...we are certainly not able to help the sheer numbers of people we were helping previously in our face to face service.”*

Some people discussed the difficulties involved in talking to health professionals using remote methods. Those experiencing trauma and anxiety have difficulty expressing this over the telephone. Non-verbal cues will be missed. GPs raised concerns that remote consultations reduce the opportunity to identify a patient’s potential alternative agenda i.e. the patient’s underlying health worries or problems that are not part of the initial presented complaint. Safety netting has also been cited by a GP as being more difficult to carry out over the phone than face to face.

Conversely, some healthcare professionals suggested that they had had increased engagement with some people experiencing homelessness who prefer telephone consultations. Homeless people experience difficulties attending specific appointment times due to chaotic lives, transport issues, or no means of telling what time it is. Additionally, one DOTW GP told us: *“I have heard rough sleepers comment on feelings of embarrassment about*

their appearance or their hygiene, and they don't want to sit in waiting rooms with 10 other people.” Telephone consultations remove some of these barriers.

8.2.2 Loss of usual “trusted” drop-in, outreach and mobile clinic healthcare provision

Suspension or reduction of walk-in services, mobile clinics and outreach services means many people from the selected groups do not know where to go for healthcare. Some are unaware of service changes and that they can no longer walk into a GP surgery. Others believe that GPs are closed or that A&Es aren't providing their usual service.

“We saw a chap in a hotel with a large wound on his leg. He had been to A&E pre COVID and had it sutured. It was recommended he have the stitches removed 10 days later...And then for a few weeks during the process of COVID he didn't know where he could go and get it sorted. Eventually he came to our rough sleeping hotel and we reviewed him and he told us ‘I have had these stitches in my leg for three weeks’ and they needed to be removed. The stitches were a real mess, they were embedded, they were hard to get out, it was infected. Pre-COVID he could either have walked into A&E with ease and got that sorted, or he could have gone to a walk-in centre.... But now, because it is harder to get through, stuff like that gets left.”

GP for Doctors of the World

Suspended/reduced service provision has resulted in lost opportunities for healthcare encounters and increased risk of poor health in individuals experiencing exclusion from mainstream health services. As one staff member of an NGO supporting women working in the sex-industry explains: *“A lot of our services are relationship based or outreach. And on outreach we reach the women we wouldn't normally be able to reach and those possibilities have gone.”* It is now harder to stage early interventions or recognise when an individual needs additional support or medical attention. For those who depend on these services as their only source of healthcare, the impact is significant. There are concerns from those we interviewed that when restrictions are lifted, and services resume they will be flooded by the increased need.

It is important to recognise that interviews identified innovative approaches some CVS organisations are taking to mitigate the loss of usual service provision. These include medical outreach provision on foot rather than using the mobile clinic van (which was considered an infection risk) and telephone outreach with people already known to the service.

8.2.3 Suspension of supported access to mainstream health service providers

Interview findings revealed that members of the selected groups are more likely to seek healthcare via a trusted source, such as an NGO, than independently access mainstream

services independently. However, most organisations have had to suspend their service offer of direct support for medical consultations. Fear of navigating the healthcare system unsupported was identified as a challenge across the groups. Service changes because of the pandemic has made understanding routes of access to care more challenging. As one interviewee who has worked closely with sex-workers said: *“They need help to access services and if everyone is in quarantine how is this going to happen?”*.

8.2.4 Reduced secondary care services

The COVID-19 pandemic has made access to some secondary care services more difficult. There has been a suspension of many secondary care services considered to be ‘non-urgent’, and service-providers we interviewed expressed concerns this would lead to an increase in morbidity and mortality from non-COVID-19 related disease.

Most sexual health services have moved to phone appointments and are sending postal kits for self-testing. This requires crossing several potential barriers: access to a telephone, the language and literacy skills necessary to follow testing instructions; and a stable address for the kit to be posted to. It has particular relevance to sex workers who are already at increased risk of sexually transmitted infections and have experienced a reduction in outreach services.

There are reports that GPs are finding it increasingly difficult to make referrals to secondary care.^{29,30} Our interview findings support this. Even when new referrals are accepted, many patients are not currently being seen. People in vulnerable circumstances often do not have access to information resources or support networks to help them navigate and come to terms with new diagnoses. Additionally, they may not feel able to ask questions or contact health professionals to discuss their concerns. Many may have emotional or mental health problems and receiving a diagnosis remotely without an immediate offer of treatment could exacerbate existing anxieties or depression.

The suspension of secondary care services will result in even longer waiting lists and many service providers expressed concern about this. People belonging to the socially excluded groups considered in our study are more likely to experience ill health and present later to a health professional. Therefore, delayed access to specialist care will have a disproportionate effect on them compared to the general population. One GP told us: *“The fact that all other stuff has shut down is a great worry. The local trust already had a massive waiting list – what*

²⁹ Practice Index. (2020) *NEWS: GP alarm at reduced access to referrals* doctors.net.uk. Retrieved 13th May 2020 from <https://practiceindex.co.uk/gp/blog/news-gp-alarm-reduced-access-referrals/>

³⁰ Pulse. (2020). *GPs still unable to refer patients to secondary care despite national guidance* Retrieved 30th April 2020 from <http://www.pulsetoday.co.uk/clinical/clinical-specialties/respiratory-/gps-still-unable-to-refer-patients-to-secondary-care-despite-national-guidance/20040758.article>

is going to happen? We have people who already experience health inequality going into a system with huge backlogs.”

8.2.5 Suspension of specialist services or reduced flexibility of critical support services

Drug and alcohol services

There has been increased engagement with services around substance and alcohol misuse by people experiencing homelessness since being accommodated in hotels. Interviewees offered several possible reasons for this:

- Reduced availability of illicit drugs, including heroin, media reports suggest this is due to reduced global travel, tighter border restrictions and slowing of movement within the country³¹
- Inability to afford street drugs due to the impact the pandemic has had on income sources
- Difficulties accessing street drugs while isolating in hotel accommodation
- Choosing to address addictions now they have greater stability in their lives
- Addiction relapses due to boredom and/or deterioration in mental health.

Interviews suggest there has been an increased demand for drug and alcohol services, but they too have been subject to reconfiguration because of COVID-19. Interviewees commented on closures of detoxification units, reduced flexibility of addiction services and delays as services adjusted to new ways of working.

For newly released prisoners with addictions, the reduction in drop-in support services is particularly problematic: *“We have one service user who was released a couple of weeks ago. He has a very chaotic lifestyle and uses drugs significantly, but the safety net for him is just gone. You can’t just walk into a service and say, ‘I need help’... and your probation office is shut, all that stuff is just going to be 10 times more difficult.”* Staff member of Through the Gate

One person experiencing homelessness and in recovery from addiction shared how the loss of physical face-to-face addiction support has affected them: *“I think for me, it’s when we went into lockdown, being in recovery, and how important the meetings are for me, to keep me going, to keep me maintained. We’ve got zoom and there are meetings online, but I’ll tell*

³¹ The Guardian. (2020). *Coronavirus triggers UK shortage of illicit drugs*. Retrieved 30th April from <https://www.theguardian.com/society/2020/apr/12/coronavirus-triggers-uk-shortage-of-illicit-drugs>

you what, I would love a meeting... a proper AA, NA meeting, to keep us safe that way."
Pathway EBE

We heard examples of remote methadone prescriptions working well and being collected on time. Data from the Royal College of Psychiatrists reports restricted pharmacy access for some service users, due in part to reduced capacity; and they cite situations where provision of supervised consumption is being refused.³² One healthcare professional expressed concerns of overdose risk in situations where there has been a switch from daily to weekly methadone prescriptions to reduce frequency of attendance at pharmacies.

Mental Health Services

A reduction in the availability and breadth of mental health services has an impact on both people with existing mental health problems and also those who are experiencing new or increased difficulties with their mental health during the pandemic.

Changes to mental health services

The same barriers faced in accessing primary and secondary care apply to accessing mental health services. The presence of trust and effective communication are particularly important in enabling access to effective care. Physical face-to-face encounters promote trust and offer greater opportunity for communication of mood and feeling. Face to face counselling, drop-in services, and peer-support groups have been suspended as part of measures taken to control the spread of COVID-19. Interruption in these services and loss of continuity of contact with a trusted counsellor, support worker or peer network may have a deleterious effect on mental health. Some people do not know where to seek help at this time. Say It Loud Club told us that half of the people (30/60) who had accessed their services during lockdown reported anxiety or worsening of mental illness during lockdown, but felt unable to seek help, due to shame and not knowing whether mental health problems could be reported during the pandemic.

It is harder for mental health services to offer effective alternatives to face-to-face consultations, therapy and support. As one GP told us, mental state assessments are complex and a challenge to perform remotely: *"How do you do this down the telephone; how do you deliver the support. You can do a lot of stabilisation work for someone's mental health, but it's difficult to move things forward; difficult to assess suicidal ideation without looking at their eyes; really tricky, really hard to gauge how safe a situation is; and as a clinician feel confident that you're leaving this person in a safe place. And [know whether] there is an adequate safety network around this person".*

³²RCPsych. (2020). *COVID-19: Working with vulnerable people*. Retrieved 29th April 2020 from <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/community-and-inpatient-services/covid-19-working-with-vulnerable-patients>

Long waiting lists for mental health services prior to COVID-19 were commonplace. A Through the Gate employee spoke of the difficulty linking prisoners requiring support into mental health services on their release due to the long waiting lists for community services. There was significant concern among the participants that a reduction in service provision, paired with an increase in need, that the backlog of cases requiring attention post-COVID-19 is going to be unmanageable, with a gross deterioration in service accessibility.

Children's services

Most children rely on parents or caregivers to act as gate-keepers to accessing healthcare and therefore children from the groups under study will face many of the same barriers to healthcare as their parents. One mother spoke of the difficulties she has experienced in accessing healthcare for her daughter since the pandemic: *"I have received a letter to make an appointment [for my daughter] but I need an access code from the GP. I have been calling the GP all week, but no one can help me. Before I would have just taken the letter to the GP and they would have checked the letter for me and given me the code for online."*

There has been a reduction in paediatric presentations to hospitals across the country since the COVID-19 pandemic and in a published statement the President of the Royal College of Paediatrics and Child Health expressed concerns about the consequences of delayed presentations of non-COVID related disease: "We've recently heard reports of a small but worrying number of cases where children may have become very unwell or even died because they weren't seen early enough."³³ The fear and uncertainty around accessing hospital or primary care at this time compounds the barriers to healthcare already faced by many of these children, and increases the health inequalities they experience.

For children whose parents or caregivers do not access healthcare for their child when required, social distancing and isolation measures have reduced the opportunity for other adults, such as school nurses, health visitors or social workers, to act as healthcare advocates. This increases their vulnerability to poor health outcomes.

8.3 Difficulties in accessing remote services

Many GP and hospital clinic consultations are now being provided via the telephone or online. This presents challenges and risks for the groups included in this report.

"Getting access at the moment is like going back to the beginning, it's really hard to reach health support. Over the phone I think it is not enough." Asylum seeker

³³ RCPCH. (2020). *COVID-19 - statement on delayed presentations*. Retrieved 29th April from <https://www.rcpch.ac.uk/news-events/news/covid-19-statement-delayed-presentations>

8.3.1 Digital exclusion

Digital exclusion was a recurring theme throughout our interviews. It affects access to information, benefits, housing support, peer support, social contact and education. It currently also has a significant impact on the ability of many to access healthcare. As one Community Outreach Nurse explained: *“Access to Wi-Fi is an essential need now, it’s not a luxury item anymore. It’s needed for access to benefits, housing support, health. You can’t expect people who are on benefits to pay for it. It’s expensive. You are expecting people to do more online but if there is no Wi-Fi then you can’t do it.”*

Telephone and online consultations rely on a person having access to a device, phone credit or internet access. One DOTW staff-member told us that 30% of the homeless people who moved into hotels did not have access to a phone. The following statement from one asylum seeker was consistent with several interview findings: *“We don’t have enough credit to call the GP and sometimes the call can take really long.”* There were complaints about long phone waits to speak to a GP receptionist and particularly lengthy calls if an interpreter was included in a consultation. For many the expense of phone credit and data is a significant barrier to remote healthcare access.

To reduce footfall through GP surgeries and address concerns about the risks of virus transmission associated with handling of paper documents some surgeries are offering online registration and prescription services. However, this is inaccessible to those without the technical capacity to register or the literacy or language required to follow online instructions.

Evidence from interviews is that digital exclusion has prompted some support services to provide phones, technology, credit/data to their clients and support development of digital literacy. This could be viewed as an opportunity for people to engage digitally with a broader, more diverse service offer. Nonetheless, as the Deputy CEO of Leeds GATE warned: *“While this pandemic has highlighted opportunities for new ways of working, we need to enable digital inclusion and that is very difficult at this time”*.

8.3.2 Language barriers to remote services

Language barriers to healthcare pre-existed the COVID-19 pandemic but a shift to remote working has increased the inaccessibility of services.

Language is integral to doctor-patient relationships. It can enable trust and is important in ensuring safety with respect to diagnosis, management and prescription. In England anyone accessing primary care and is in need of an interpreter is entitled to have this provided free at the point of delivery. However, according to our interview findings, this is not the common experience for many migrants in vulnerable circumstances accessing mainstream health services. Many are not offered or are refused interpreters and, contrary to published

guidance, have to rely on family members or friends to translate for them.³⁴ One asylum seeker told us he has been acting as an interpreter for his community since the move to remote services and has been required to help 375 different families in the past month.

Asylum seekers we spoke to articulated concern that they are unable to express their symptoms well enough over the phone in order for the clinician to make an informed diagnosis and management plan. They are also worried that they will not understand the advice given by the doctor. This leaves them anxious and afraid and they have no trust in the consultation.

Even when a professional interpreter is offered there are challenges. We heard an account of patients dropping off the call whilst the GP is trying to arrange the phone interpreter. Additionally, three-way consultations are time consuming, which can have a financial impact if the patient is covering the cost of the call.

8.4 Barriers preventing or delaying healthcare seeking

8.4.1 Fear and lack of trust in health professionals, the NHS and government

Our interviews identified fear and distrust to be common deterrents to accessing healthcare across all groups. This is discussed in greater detail in section 7.

8.4.2 Fear of overseas visitor charging and NHS data sharing with the Home Office

Fear of overseas visitor charging and NHS data sharing with the Home Office is a widely recognised deterrent to some migrants in vulnerable circumstances needing to access healthcare. Our interview findings were consistent with this. This is discussed in more detail in section 7.

8.4.3 Fear of catching COVID-19 in health facilities

Fear of catching COVID-19 if leaving the house or entering medical facilities has been cited as a reason for not seeking healthcare at this time. A nurse expressed her concerns that the message that it is safe to go to the hospital isn't being communicated to the communities she works with. One member of the Gypsy, Roma and Traveller community told us: *"People are so scared of the coronavirus. They are too scared to go anywhere.... They are frightened, no matter what the problem is.... They are afraid that if they go into hospital they might not come out."*

³⁴GOV.UK. (2020) *Language interpretation: migrant health guide*. Retrieved 26th April from <https://www.gov.uk/guidance/language-interpretation-migrant-health-guide>

9. FINDINGS: IMPACT OF COVID-19 ON UPTAKE OF HEALTHCARE SERVICES

BOX 6: Uptake of services is different to what would normally be expected
<p>People are using healthcare services for non-COVID-19 health problems less than would normally be expected</p> <p>Use of healthcare services has reduced for the population in general, for the selected groups we expect there is a substantial reduction in healthcare use but do not know the extent of this</p> <p>There is increased healthcare and addiction service engagement by people experiencing homelessness who are currently housed in hotels due in part to:</p> <ul style="list-style-type: none"> • Increased accessibility of healthcare and support services • Provision of stable accommodation and food allowing health to become a greater priority than in normal circumstances
IMPLICATIONS
<p>Delayed diagnosis and management of disease, poor control of pre-existing long-term conditions, reduced opportunity for health promotion and disease prevention activities. Therefore, we can expect an increase in health inequalities already experienced by the identified groups.</p> <p>‘Everyone in’ hotels have provided some opportunities for improved health and wellbeing for PEH because of their access to secure, stable accommodation with onsite support and access to technology</p>
<p>Utilisation of health services for those experiencing vulnerable circumstances is unlikely to improve unless:</p> <ul style="list-style-type: none"> • People have secure and stable accommodation • Specific effort is made to increase access in groups experiencing vulnerable circumstances

9.1. The impact of COVID-19 on uptake of healthcare services for non-COVID-19 problems

GPs providing primary care services to the group we spoke to expressed concerns about the reduction in the number of patients who are seeking medical review during this period of lock-down.

“The expressed demand for healthcare has gone down a lot. But I think this belies the true needs (...) The longer the lockdown continues the greater the risks of service users who are not

seeking or receiving healthcare.” GP providing healthcare service to asylum seekers and refugees

“Just looking at the numbers we are dealing with on the phone I am sure we are not seeing the proportion of numbers we are normally seeing when we run our usual clinics...we are certainly not able to help the sheer numbers of people we were helping previously in our face to face service.” GP for Doctors of the World

GPs are not seeing the number of people for routine health concerns and chronic disease management that they would expect to see under normal circumstances. Our interview findings of reduced presentation to healthcare providers is corroborated by national evidence. Data collected by the RCGP showed routine clinical activity in general practice had reduced by a quarter and PHE data shows that A&E attendance has fallen during the pandemic.³⁵³⁶ In Scotland urgent suspected cancer referrals by GPs have declined by over 70% following reduced patient presentation and at the end of March the number of patients presenting to A&E with heart attacks had halved.³⁷³⁸

Consequences of reduced healthcare contact include:

- delayed diagnosis and management of disease
- poor control of pre-existing long-term conditions
- reduced opportunity for health promotion and disease prevention activities

Health impacts include increased risk of poorer health outcomes, the possibility of irreversible disease progression and/or reduced quality of life while awaiting treatment. People from socially excluded groups are already more likely to present late to healthcare services for reasons discussed in the report. Additional delays because of the pandemic means disease could be well advanced before intervention occurs and contributes to the health inequalities they already experience.

We came across examples of good practice to mitigate against these concerns. Some GPs and CVS organisations are carrying out proactive patient reviews and welfare checks over the telephone.

³⁵ GP Online. (2020). *Millions of patients 'avoiding calls to GP' during COVID-19 pandemic*. Retrieved 19th April 2020 from <https://www.gponline.com/millions-patients-avoiding-calls-gp-during-covid-19-pandemic/article/1681384>

³⁶Public Health England. (2020). Retrieved 1st May 2020 from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/883660/EDSSSBulletin2020wk18.p

³⁷ Pulse. (2020). *GP urgent cancer referrals decline by more than 70% as 'fewer patients come forward'*. Retrieved 29th April from <http://www.pulsetoday.co.uk/clinical/clinical-specialties/respiratory-gp-urgent-cancer-referrals-decline-by-more-than-70-as-fewer-patients-come-forward/20040662.article>

³⁸ Public Health England. (2020)

9.2 The impact of 'Everyone in'

A letter sent from NHSE and NHSI to all GP practices on 27th March stated: "Practices should agree how they can most effectively connect and support locations that are accommodating people who are homeless." Interviewees reported people who experience homelessness have generally had increased access to medical services during the pandemic as NGOs, volunteers and GP surgeries have coordinated their efforts to provide holistic health services to people accommodated in hotels. Having a physical address has facilitated healthcare activities such as the sending out of prescriptions and delivery of medications. Having access to a telephone and a place to charge mobile phones has enabled increased engagement with healthcare services.

Interviewees reported that there were signs of increased engagement with health services facilitated by the provision of safe and secure accommodation. Service providers have seen an increase in the use of drug and addiction services as people have been able to progress to addressing addiction recovery as their immediate needs for shelter and food have been met. Service providers hope that the stability afforded by secure accommodation will increase engagement with health services in the medium and long term.

10. FINDINGS: HOW COVID-19 HAS IMPACTED PEOPLE'S LIVES

BOX 7: How COVID-19 has impacted people's lives

The COVID-19 control measures have had significant impacts on the lives of people from socially excluded groups.

Negative impacts because of the reduction and changes in many essential services

- Asylum claims have been put on hold, creating anxiety, uncertainty and preventing people moving on with their lives.
- Changes in prison processes have led to the loss of usual safety nets for recently released prisoners.

Social and Psychosocial Impact

- School closures have led to exclusion from education of children without digital access, physical space, or resources for other support.
- Food insecurity for children has also been worsened due to lack of access to school meals
- There have been reported increases in violence: domestic violence, hate crimes against excluded groups and violence during work for sex workers
- Many of our identified groups are facing isolation and exclusion due to the drop in face-to-face interactions

Challenges with accommodation

- There is a lack of access to basic amenities at some traveller site
- Those living in unstable accommodation face the threat of eviction if they display symptoms of COVID-19
- Some groups are particularly at risk to facing eviction and homelessness due to changes due to changes in financial circumstances as a result of COVID-19

Financial and economic impacts

- Job losses or the loss of work have been common and significantly impact those working informally or without access to benefits
- Navigation of the benefits system has been challenging for many without access to the internet or face-to-face support
- New destitution and homelessness has been reported, particularly among those with no recourse to public funds

IMPLICATIONS

People are living with uncertainty, anxiety, violence, isolation and poverty as a result of COVID-19. Many people have experienced destitution as a result of job loss, insecure accommodation, difficulties/exclusion from access to public funds.

In order to reduce the negative impacts COVID-19 has on the lives of people living in vulnerable circumstances there needs to be:

- Education provision for children without access to the internet or computers at home
- Social welfare benefits that are accessible and responsive to acute needs
- Protection from eviction for all (including roadside evictions)
- A recognition of undocumented immigrants, and others working illegally, to allow access to social welfare in times of crisis
- An end to the vilification of these groups in the media
- Ongoing access to refuges and places of safety for those experiencing violence

10.1 Impact on Services

All organisations have had to make adaptations because of the pandemic to varying degrees. As mentioned throughout the report, loss of access to usual support services has been a key challenge for people who are socially excluded. This is true for people experiencing chronic uncertainty or acute changes in their circumstances. Some examples are given below.

10.1.1 Immigration

As documented in the introduction, there have been multiple changes to immigration processes for asylum seekers. Some migrants have become hostages of the asylum-system as immigration processes have been paused. As one asylum seeker told us, the sense of uncertainty and helplessness impacts upon mental wellbeing: *“We don’t know what is happening. We don’t know how much longer we are going to have to wait for. You feel uncertain. You don’t know what you are going to do with your life or what next step to take. Sometimes I feel like I’ve waited too long. I need to get my life in order. I need to do things. There is nothing I can do about it.”* Asylum seeker

Whilst the processes of applying for refugee status have been suspended, people seeking asylum are still receiving decisions of refusal. One charity worker explained the challenge of only providing remote support when clients are facing huge psychological and practical challenges due to refusal decisions: *“One of them got his decision and he was messaging me throughout the day saying: ‘Well, that’s it, I give up. There is nothing left to live for’ and it’s having to sit by your phone, whereas before we could have invited them in... And I have a fear for them. Because people can write things when they are really upset but who am I to say they are not going to act on it? And so how strong can your intervention be if they aren’t going to*

answer the phone?” Charity worker supporting unaccompanied asylum-seeking children and young people

As discussed in section 5, changes in the usual procedures asylum seekers have to follow have not been communicated by authorities in a timely manner, which has caused additional confusion and anxiety to those already trying to navigate a complex asylum system.

10.1.2 Prison Services

On release from prison, for those with chaotic lives and complex needs, the prison itself can act as a safety net. COVID-19 has resulted in changes to custody arrangements and administration of the courts as prisons attempt to reduce the number of people they are holding. Some of the clients in the most vulnerable circumstances may be sent to a new prison, away from services to which they are known, making them less likely to engage with services.

“People are ending up very displaced in custody which makes release planning much more difficult.... also some of our more chaotic services users have been in a few times, well a lot of times, so we can build up those relationships with them but if they are placed elsewhere they don’t know them, they won’t trust those teams, they won’t share as much information.” Staff member of Through the Gate

10.1.3 Bereavement support

Lack of access to bereavement support during the pandemic has been highlighted as particularly challenging for some of our groups with limited social support networks. Inability to access these services when a friend or relative has died, especially of COVID-19, has created confusion, frustration, and a sense of being forgotten.

“It was horrible. And there was nothing from any doctors or anything. They just didn’t seem to care about me or my sisters even though my dad had just passed away with this virus, they didn’t seem to know what advice to give us which I thought was a bit unprofessional” Pathway EBE

10.2 Social and psychosocial Impact

10.2.1 Excluded from education

Interviewees reported that school closures have had a disproportionately negative impact on our selected groups due to limited access to the internet, laptops, and academic support within the home. Although the government guidance advised that children who are

vulnerable should continue attending schools, their definition of vulnerable was narrow³⁹. It did not include those who did not have a social worker or education health and social care plan, or were not identified by children's social care services or local authorities as being vulnerable. This made it difficult for schools to physically support children facing other vulnerabilities during the pandemic.

Many children within the Gypsy, Roma and Traveller communities have been cut out of education because it has moved online, and there were concerns from our interviewees that children are completely disengaged from education. Parents with low literacy and little physical space to provide home schooling are concerned that their children will be disadvantaged in their educational opportunities. Similarly, many children of asylum seekers have no access to technology and may have parents whose English proficiency limits their ability to support their children with schoolwork. School closures are likely to widen the learning gap between children from lower-income and higher-income families and increase inequalities in education outcomes.⁴⁰

“Since schools closed there has been no contact from school at all and we have no access to the internet. When they go back to school they will have forgotten everything.” Member of the Gypsy and Traveller Community

School closures also exacerbate food insecurity for children living in poverty. Government guidance states schools have a responsibility to ensure eligible pupils have continued access to free school meals where the pupil is not attending school.⁴¹ However, a member of the Gypsy, Roma and Traveller community informed us that none of the children on her site had received this. Access to nutritious food is vital for a child's health, growth, and development.

10.2.2 Increase in abuse and violence

Across the whole UK, since the COVID-19 restrictions have been implemented, a rise in domestic violence has been observed⁴². This rise has been linked to increased time spent

³⁹ Department for Education. (2020). *Supporting vulnerable children and young people during the coronavirus (COVID-19) outbreak - actions for educational providers and other partners*. Retrieved 18th May 2020 from <https://www.gov.uk/government/publications/coronavirus-covid-19-guidance-on-vulnerable-children-and-young-people/coronavirus-covid-19-guidance-on-vulnerable-children-and-young-people>

⁴⁰ The Lancet. (2020). *COVID-19, school closures, and child poverty: a social crisis in the making*. Retrieved 1st May 2020 from [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(20\)30084-0/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30084-0/fulltext)

⁴¹ Department for Education. (2020). *Providing free school meals during the coronavirus outbreak*. Retrieved 18th May 2020 from <https://www.gov.uk/government/publications/covid-19-free-school-meals-guidance/covid-19-free-school-meals-guidance-for-schools>

⁴²The Guardian (2020). *Charges and cautions for domestic violence rise by 24% in London*. Retrieved 18th May 2020 from <https://www.theguardian.com/society/2020/apr/24/charges-and-cautions-for-domestic-violence-rise-by-24-in-london>

The Guardian. (2020). *Revealed: surge in domestic violence during Covid-19 crisis*. Retrieved 18th May 2020 from <https://www.theguardian.com/society/2020/apr/12/domestic-violence-surges-seven-hundred-per-cent-uk-coronavirus>

indoors, stress caused by deterioration in financial circumstances and lack of access to previous support networks. The groups included in this assessment experience these risk factors but also face more challenging situations which place them at additional risk of domestic abuse. For example, women seeking asylum can experience extreme isolation with limited social networks, and migrants on spousal visas with no-recourse to public funds can face destitution if they separate from their partners. Others live in crowded conditions or are more likely to have experienced job loss due to the pandemic.

Children and young people are also at increased risk of abuse. Interviews highlighted safeguarding concerns associated with heightened tensions within families forced to spend long time periods in small spaces during this stressful time. Of additional concern, if a child is experiencing abuse during lockdown, there are fewer opportunities for them to seek help or for other adults to spot the signs and intervene. One NGO worker spoke of a young asylum seeker who experienced verbal and psychological abuse by care staff at his residence: *“He felt trapped with no escape and self-harmed. He had to go to A&E and be seen by the Crisis team. I believe this could have been avoided if it wasn’t lockdown.”*

Concerns have been raised regarding increased vilification and hate crimes towards people who are Gypsy, Roma or Travellers. Some report their community have been blamed for the spread of coronavirus. Acts of violence and verbal abuse have been reported. One worker from Southwark Travellers Action explained: *“I’m worried about hate crime...in these sorts of situations some people like to blame particular communities and the gypsy and travellers are particularly susceptible to that”.*

Lockdown has exacerbated violence towards sex workers. Lockdown measures have presented fewer opportunities to work due to lower footfall and higher police activity. Sex workers may be unable to pay their drug-dealers, indebting them and placing them at high risk of violence. Sex workers are reportedly taking greater risks to maintain their income and the clients who risk arrest to solicit their services can be violent. One sex worker explained that: *“workers whose better [less aggressive, less boundary pushing] clients have dropped off, are getting more pushy, controlling and aggressive clients who are aware of the situation and the power they have now. Clients are asking to pay less or are being aggressive pursuing bookings.”*

10.2.3 Disconnected from communities

People across the UK have been physically separated from friends and family during lockdown, but the majority are able to remain socially connected through telephones and the internet.

However many of the groups included in this assessment have experienced more extreme social isolation. Without reliable internet access, or money to afford phone credit, people are separated from their support networks. People detained in immigration removal centres are no longer having visitation services. Prisoners are not allowed visitors and as far as possible

are being moved into single cells. Those who usually rely heavily on services for support, have been cut off from face to face contact and, often, remote access.

Closure of services has also meant that people experiencing modern slavery and trafficking are less visible and therefore identifiable by members of the public. Despite this, people continue to be referred into the National Referral Mechanism and community services for this group.

“The sectors where we know slavery exist in the UK, so takeaways, restaurants, nail bars, car washes, we know that’s where people have been identified. All of those have shut down, so where have those people gone? So we predict there will be demand [for our services] as the social restrictions loosen.” Director of Unseen

10.3 Impact on housing

10.3.1 Unsuitable accommodation

Provision of accommodation for Gypsy, Roma and Travelling communities is reported to have been inconsistent between local authorities nationwide. Some sites are very overcrowded as people have attempted to find a base whilst there are restrictions on movement. The lack of running water and the use of shared bathrooms at some sites makes it very challenging to follow government guidance on COVID-19, as has been described in section 5. Access to water and sanitation has been particularly difficult for those travelling or without permanent sites. Interviewees reported that people continue to be evicted or moved on from the roadside by local authorities, despite guidance regarding non-essential travel.

“There are fewer people travelling. But things that they would have access to normally like washing facilities at leisure centres, they are all shut... So it’s basically facilities like that, sanitation facilities, which is a problem that in the past hasn’t existed to such a degree and is now becoming a massive problem for those who are still having to travel. And people are having to travel largely because they don’t have a permanent base they can settle or stop on”
Policy Officer from National Federation of Gypsy Liaison Groups

10.3.2 Evicted for displaying COVID-19 symptoms

Many of the groups we included in this assessment live in unstable accommodation. Undocumented migrants who are sofa surfing or staying with friends, with no formal accommodation agreement, may conceal COVID-19 symptoms, or display them and risk losing their accommodation. Say it Loud Club reported to us that 20 out of 60 people who accessed their services within a particular time period of lockdown reported that their friends were no longer able to support them due to fear that they could be infected with COVID-19.

“I know of a Vietnamese man who was sofa surfing and being supported by the Vietnamese community in London. He always had somewhere to sleep and always had something to eat as people were inviting him to their home. He developed a cough, and no one would take him in after that. So now he has become street homeless, never having been street homeless before.” Staff member of Doctors of the World

Similarly, domestic workers’ employment may be terminated if they display symptoms, rendering them without a job or a home. We were informed of one domestic worker who was hospitalised with COVID-19, and on recovery, was not permitted to return to her employer's home. Likewise, one interviewee explained that families have been evicted from traveller sites when a household member has exhibited symptoms of COVID-19.

A positive measure taken by the Home Office has been to stop all evictions from asylum accommodation, even once a person has been granted refugee status.

10.3.3 Accommodation insecurity

Due to immigration ‘right to rent’ checks those with irregular immigration status are often obliged to rent from illegitimate landlords. During COVID-19, legitimate landlords have shown some flexibility with tenants facing financial challenges. Those with irregular immigration status are not usually extended this benefit and have faced eviction. This has contributed to the large number of people that have been reported, by community and voluntary sector organisations, as being newly destitute and homeless due to COVID-19.

Sex workers are extremely vulnerable to losing their tenancy and being made homeless during this time. We were told at interviews that sex workers are experiencing a loss in income due to lower footfalls and greater policing and are placed at high risk of destitution as they are deterred from seeking social support due to marginalisation and discrimination. One sex worker shared her anxieties with us: *“I can't overstate either that regardless of whether workers are working at the minute, the financial situation we're all in is terrible. Most people are having problems with landlords, but sex workers are in a situation where being outed to their landlords, as well as friends and family, is more likely. Being outed in this way is also devastating – workers will be evicted, crucial friends and family support will fall away”*.

Good progress has been made during the pandemic to accommodate those sleeping on the streets, mainly in hotels. Ordinarily it is not unusual for prisoners to be released onto the streets, however, during the pandemic, all are being accommodated on release. Nonetheless, it is important to note that not all people who street sleep have been housed, some have declined accommodation because of their pets or complex mental health needs. Furthermore, many people seeking asylum, who have been destitute for a long time, have been housed in Local Authority accommodation. However no agreements have been made about how long emergency accommodation will be provided for, with many concerned that people will again suffer the trauma of being returned to the streets after lockdown measures are released.

Dispersals of asylum seekers to other parts of the country have been paused, people being left with the uncertainty of their permanence in their current location. Asylum seekers are reluctant to register with GPs or begin to access local services in anticipation of imminent relocation.

10.4 Impact on employment and finances

10.4.1 Job losses and destitution

The COVID-19 pandemic comes at a time when many in the UK are already living in poverty or destitution. During COVID-19, due to pressures on businesses and temporary closure of many workplaces, many have lost their jobs. Many examples were reported during interviews.

A number of people in the UK are formally employed on temporary visas that do not permit the bearer to any access to public funds such as housing or employment benefits. This means that some people have lost their jobs during COVID-19 but have no access to public funds or savings and have become newly destitute. These temporary residents, who may have ordinarily returned to their country of origin after a job loss, are currently unable to do so due to international travel restrictions.

Some people, such as sex workers or those with irregular immigration status, make an income through informal work in order to survive. People working informally, who have lost their jobs or can no longer work, are not eligible for the benefits, protections and entitlements offered to others during the pandemic. Many of these people, previously managing to support themselves, have become newly destitute.

“Now the highest number of people we see, they are not our usual service users, but people who now have lost employment, illegal employment, they have lost their means of support, and have become homeless. They have been washed out” Casework coordinator of an NGO

Another group that has been heavily impacted by job losses are the Gypsy, Roma and Traveller community. This is because many are self-employed, or the work undertaken is informal or seasonal. The manager of Southward Travellers action group explained how this loss of employment is not only concerning for the immediate household but for extended families and communities: *“What I am really worried about, is that the people who work...they very much share their income with the poorer people on the sites, so they have been there almost as a safety net on the site, and I’m really worried... they won’t be able to support the community as much as they used to”*.

The reported rise of destitution by interview participants is corroborated by DOTW staff operating their advice line. They report a significant increase in calls since the pandemic from people facing destitution. DOTW has been required to divert resources to match this increase

in demand. A staff member commented: *"We're seeing a real impact on undocumented individuals and families with no recourse to public funds... community support and informal work has completely dried up."*

10.4.2 Working conditions

Mistreatment within workplaces is also reported to be more common, due to the lack of options and workers' rights that people have. People affected by trafficking and modern slavery are unlikely to have a choice whether or not to work or travel during the pandemic or have access to personal protective equipment when required. They may be moved into other areas of work if their usual workplace closes due to the pandemic, which may expose them to new dangers.

Domestic workers are known to experience high levels of physical, verbal and sexual abuse. Many are being made to work on their days off and without pay during the pandemic. They have little choice, because for many their work is also the source of their food and accommodation. Some domestic workers who have lost their jobs during the pandemic have become newly homeless and destitute.

10.4.3 Access to essentials

Asylum seekers and refused asylum seekers receiving Section 4 support are not entitled to banking services (including chip and pin and contactless card payments) and can only access their financial support through the ASPEN card. This group have reported difficulty accessing their weekly cash allowances as cash machines stand empty during lockdown: *"Last Monday, because they put the money in the account every Monday, I tried 12 different cash machines before getting the money. I know a family that couldn't get the money out of the cash machine. They called Migrant Help. It's been two weeks now and they haven't fixed that issue. So we started seeking different places where they can get food."* Asylum seeker

Even with access to this allowance (less than £40 per week), often the money is insufficient to support all of a person's basic needs. Like other groups included in this assessment, asylum seekers rely heavily on CVS organisations for access to food, clothing and internet/mobile data. Some domestic workers have also not been receiving sufficient food from their employers during this time. With the reduced face-to-face service provision of many organisations during COVID-19, many groups have had to find other means of accessing essentials or they go without.

10.4.4 Navigating the benefit system

Job losses have been experienced across the UK due to COVID-19 therefore many individuals require new access to the welfare system. The system to access benefits can be daunting and challenging for our identified groups and the pandemic has made it even harder. Those with

language barriers or low literacy benefit greatly from face-to-face support in completing applications, which is now unavailable through many organisations.

People who are homeless, recently released from prison, live on Traveller sites or are accommodated by the Home Office often have very little access to the internet and now cannot complete online benefit applications due to the closure of public venues with computers. Many asylum seekers reported difficulties with making applications for financial support during the pandemic without the physical help of charity volunteers and other key workers. Practical needs such as dealing with lost documentation, scanning documents and opening a bank account are more difficult to manage during lockdown.

A positive measure taken by the Home Office has been that although asylum support is usually stopped 28 days after someone is granted refugee status, currently there is a process in place to allow newly recognised refugees to request support if there are delays in being able to access benefits⁴³.

⁴³ Refugee Council. (2020). *Changes to Asylum & Resettlement policy and practice in response to Covid-19*. Retrieved 18th April from <https://www.refugeecouncil.org.uk/latest/news/changes-to-home-office-asylum-resettlement-policy-and-practice-in-response-to-covid-19/>

11. FINDINGS: OVERALL HEALTH IMPACT

BOX 8: COVID-19 and measures taken to control it are likely to disproportionately negatively impact the physical and mental health of people from the identified groups

The life circumstances and pre-existing socioeconomic and health inequalities of the identified groups increase their vulnerability to indirect physical and mental harms

Identified groups are likely to be at increased risk of ill health from COVID-19

Exacerbation of pre-existing mental illness and deterioration of mental health in people who were previously well including reports of increased:

- Anxiety
- Depression
- Loneliness
- Suicide

There are many unknowns around the extent of the physical and mental health impacts specifically experienced by the identified groups.

IMPLICATIONS

Some people are experiencing poor mental health due to COVID-19. It is likely that excluded groups will continue to have negative health outcomes in the short and longer term.

To fully understand and mitigate against the negative health effects of COVID-19 for people living in vulnerable circumstances, the medium and long term mental and physical health of these groups needs to be monitored and rapidly responded to. To reduce the immediate negative health impacts on these groups:

- Support is needed with tackling the drivers and stressors of mental health problems
- Access to mental health services and alternative resources should be considered essential, with face-to-face provision facilitated where clearly needed
- Services need to be responsive to the needs of these groups

11.1 Poorer health outcomes directly resulting from COVID-19 infection

As explored in detail in sections 5 - 10, our findings suggest that many people belonging to the socially excluded groups we included are likely to have: a higher risk of being exposed to the virus; a higher risk of health conditions that increase clinical vulnerability to COVID-19; and reduced access to and utilisation of healthcare services. This indicates that these groups are likely to experience poorer health as a direct result of COVID-19 infection than the general public.

11.2 Poorer health outcomes as an indirect impact of the COVID-19 pandemic

The people from the groups included in the study did not enter this pandemic from the same position as the wider public. Their life circumstances and pre-existing socioeconomic and health inequalities increase their vulnerability to indirect physical and mental harms caused by:

- Suspension and reduction of healthcare and support services
- Additional barriers to primary care access, including GP registration.
- A switch to remote services which isolate those without access to the necessary technology and digital literacy
- Increase in psychosocial deterrents to accessing healthcare (e.g. fear of catching COVID-19 in hospitals)
- Social distancing and increased isolation
- Increasing deprivation

Harms to health are likely to be experienced for many years beyond the current crisis period.

While this study did not seek to quantify the health impact of the COVID-19 impact and government and societal response to it on the included groups, many interviewees reported an immediate impact on their mental health and well-being.

11.2.1 The indirect impact of COVID-19 on mental health and well-being

While the full impact of COVID-19 on mental health is yet to be realised, early research, surveys, and knowledge gleaned from the 2003 Severe Acute Respiratory Syndrome (SARS) and the 2012 Middle East Respiratory Syndrome (MERS) outbreaks leave no doubt that it will be profound and potentially long-term⁴⁴. The evidence base tells us that the psychosocial

⁴⁴ The Lancet. (2020). *Multidisciplinary research priorities for the COVID-19 pandemic: a call for action for mental health science*. Retrieved 18th April 2020 from [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(20\)30168-1/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30168-1/fulltext)

effects discussed throughout this report are known to increase risk for mental health problems, such as anxiety, depression, self-harm and suicide⁴⁵.

The wider impacts of COVID-19 and control measures, such as unemployment, accommodation insecurity and financial stress, are known drivers of worsened mental health and wellbeing. Many interviewees spoke of these drivers being compounded by other stressors, such as social isolation, bereavement, changes in immigration status or the loss of usual support. These have been discussed in section 10 and were described across almost every interview and focus group as having evident and significant impacts on people's mental health and wellbeing. Barriers to following guidance and seeking healthcare for COVID-19, discussed in earlier sections, were raised as being highly anxiety-provoking.

“Social distancing to them was already there, as many people were living lonely and some of our members have been living so lonely they have even forgotten how to engage and speak to other human beings... So to them it is like taking them back to the life they used to live but which they don't want to go back and experience again.” Director of Say It Loud Club

Some people in the selected groups have reportedly been responding with coping behaviours, such as increased alcohol and substance misuse. There were many that described loneliness, increased fear and anxiety, depression and sleeplessness. Some also described that people who had experienced modern slavery or trafficking were reliving traumatic experiences related to feelings of entrapment.

11.2.2 People with existing mental health problems

Many of the socially excluded groups included in our study are at increased risk of having mental health problems compared to the general population (see appendix 1). Individuals with existing mental health issues are at risk of relapse or exacerbation of their conditions during the pandemic due to disruption of mental health services, social distancing and isolation, negative changes in life circumstances, and COVID-19 related fears and anxieties. We heard many examples of deteriorating mental illness since the pandemic and lockdown measures. A GP told us one of their patients committed suicide as their mental health deteriorated very quickly under lockdown.

“We've noticed that those with mental health problems are getting worse because there is nothing there.” Casework coordinator of an NGO

“Before the coronavirus I am a very depressed person. I am on antidepressants. I have to go out every day to avoid that depressed feeling when you have a lot of things on your mind. Before the coronavirus I was a bit suicidal so I make sure I go out every day. I go for company and I go to so many groups to keep my spirits going (...) But now you can't do anything (...)

⁴⁵ The Lancet. (2020)

Access to internet [would help]. Have some activities to do with groups or have somebody to talk to. Just something that keeps you busy and your mind occupied. That will really help. And most of this comes through the internet. And I don't have the budget for that." Person with new refugee status

New or worsening mental health difficulties

Without services to support them, the management of new mental health problems may also be more difficult for this group. The vulnerable circumstances in which the groups included in our study live may mean they may have less resources and resilience for coping with these challenging times. Say it Loud Club reported a 20% increase in demand for healthcare related queries through their service; particularly related to mental health. One NGO representative working with Gypsy, Roma and Traveller communities said that people who were "just managing" their mental well-being had been "tipped over the edge" by circumstances related to COVID-19.

"So many people are getting depressed since lockdown. People who were fine before. But now they are scared, and they can't go out." Member of the Gypsy and Traveller Community

Mental health of children and young people

The mental health of children and young people has also been affected by the introduction of social distancing measures. An interview with a charity worker supporting unaccompanied asylum-seeking children and young people in the asylum system spoke of cases of deterioration of mental illness in their clients.

"PTSD can involve constant replaying of distress and trauma. Constant reminders like thinking about your asylum claim and your lost family. Now we are on lockdown this is on their mind 24/7 for some of them. It seems as though the anxiety is too much. Some of them are sleeping constantly because they don't know how they can get through this. They are so isolated." Charity worker supporting unaccompanied asylum-seeking children and young people

The mental health charity Young Minds surveyed 2111 participants up to age 25 years with a mental illness history in the UK. 83% said the pandemic had made their conditions worse and 26% said they were no longer able to access mental health support as peer support groups and face-to-face services have been cancelled, and support by phone or online is difficult for some young people.⁴⁶ Due to life circumstances and healthcare access barriers already discussed, these figures are likely to be even higher for the population of children and young people included in this report.

⁴⁶Young Minds. (2020). *Coronavirus: Impact on young people with mental health needs*. Retrieved 18th May 2020 from https://youngminds.org.uk/media/3708/coronavirus-report_march2020.pdf

BOX 9: EXAMPLES OF GOOD PRACTICE

- Involvement of people experiencing exclusion in producing and distributing COVID-19 guidance and conducting welfare checks within their communities.
- Distribution of accessible information about COVID-19 via trusted sources and in the appropriate medium to reach the target audience.
- Outreach services conducting medical assessments to determine risk of clinical vulnerability and providing social-distancing and shielding advice to people who are not registered with a GP and therefore excluded from the letter notification service.
- Proactive telephone medical reviews of people who are identified as clinically extremely vulnerable to COVID-19 to ensure they understand the shielding advice and assess their medical needs.
- Regular telephone welfare checks of people who are self-isolating or shielding.
- Provision of mobile phones, tablets, phone credit, data, internet access and support to develop digital literacy to address digital exclusion.
- Continued provision of social support via telephone and online drop-in sessions and peer-support groups.
- Continued provision of face to face medical outreach services to people experiencing street homelessness.
- Delivery of food and other essentials to those in need.
- Delivery of activity packs for children.
- Flexible provision of methadone prescriptions.

12. SUMMARY OF KEY FINDINGS

Issue:	Challenges with accessing and understanding guidance on COVID-19		
Problems experienced by people in excluded groups	Often unable to access online information	Guidance is written in language that is often not understandable	Guidance is not targeted at socially excluded groups
	Support services and networks which would normally help are closed	Guidance often does not reach excluded groups	
Implications for people in excluded groups	People in excluded groups may not know what they should be doing to protect themselves from COVID-19		
Implications for provision	<p>The development of guidance can only be effective as a public health measure for these socially excluded groups if they are:</p> <ul style="list-style-type: none"> ● accessible to people without access to telephones, television and the internet ● accessible to people in whom English is not their first language or have literacy and comprehension difficulties ● disseminated in a timely manner through the channels used by these groups ● accompanied by efforts to build trust and belief 		

Issue:	Barriers to following information and guidance		
Problems experienced by people in excluded groups	Accommodation related barriers make guidance very difficult to follow	Need to go outside frequently to obtain income, meet basic needs or manage addiction	Lack of belief in information about COVID-19
Implications for people in excluded groups	The circumstances that people in excluded groups often find themselves mean that even if they know how to, they are not able to protect themselves from coming into contact with COVID-19		
Implications for provision	<p>For people to be able to follow COVID-19 guidance, it must:</p> <ul style="list-style-type: none"> ● Consider the specific life circumstances of people facing vulnerable circumstances ● Include adequate provisions and recommendations for a range of life circumstances ● Be sufficiently prescriptive so that people with responsibility have clear instructions of how to implement guidance ● Be understandable and feasible to implement 		

Issue:	Underlying health conditions and shielding from COVID-19		
Problems experienced by people in excluded groups	People in some excluded groups may be more likely to have medical conditions which make them vulnerable to developing severe illness due to COVID-19	Many people in excluded groups do not know that they have medical conditions and should be shielding	People in excluded groups may not have the support needed for shielding
Implications for people in excluded groups	<p>People who are socially excluded are more likely to become severely unwell due to underlying health conditions, which they may be unaware of.</p> <p>Without shielding, clinically vulnerable people in excluded groups are more likely to become severely unwell from COVID-19.</p>		
Implications for provision	<p>People with underlying health conditions from socially excluded groups cannot effectively protect themselves from severe illness due to COVID-19, unless they are:</p> <ul style="list-style-type: none"> ● included within the health system so that they are diagnosed and properly managed ● identified as being clinically vulnerable through risk assessments ● offered support with shielding that is accessible and tailored to their needs. 		

Issue:	Access barriers for COVID-19 illness: factors which hinder recognition of COVID-19 illness, which delay decision to seek healthcare or delay access.			
Problems experienced by people in excluded groups	Lack of knowledge and awareness of COVID-19 and disbelief in its existence	Poor baseline of health making symptoms difficult to recognise	Fear and lack of trust in health professionals, the NHS and government	Practical problems in reaching healthcare (transport and telephones)
	Fear of being charged for healthcare	Unable to access 111 due to language or technology barriers	Suspension of usual healthcare services	

Implications for people in excluded groups	People who live in vulnerable circumstances are less likely and able to access healthcare for COVID-19 illness and receive the care they require. We might therefore expect that people in the selected groups may be at greater risk of worse health outcomes from COVID-19.
Implications for provision	<p>People living in vulnerable circumstances are more likely to access healthcare for COVID-19 illnesses if:</p> <ul style="list-style-type: none"> • They are provided with sufficient understandable information on what services are still available to them during COVID-19 and how to access them • They are supported to access services where there are practical barriers such as transport or digital exclusion • All services are free at the point of access • People are given sufficient clear, comprehensible information about NHS charging

Issue:	Access to health services for non-COVID-19 related routine or urgent care			
Problems experienced by people in excluded groups	It can be difficult to register with a GP	Routine health services have closed or have reduced service provision	Remote healthcare services are hard to access	Fear and lack of trust in health professionals, the NHS or the government
Implications for people in excluded groups	<p>People living in vulnerable circumstances are experiencing new barriers to healthcare during COVID-19, making them less able or willing to seek medical services.</p> <p>Delayed presentations or non-presentations to healthcare are likely to lead to poorer short and long-term health outcomes making it likely that the health inequalities already experienced by the identified groups will increase.</p>			
Implications for provision	<p>People living in vulnerable circumstances will continue to face access barriers unless:</p> <ul style="list-style-type: none"> • It is easy to register at GP surgeries nationwide • Vital services offer some face-to-face service provision (i.e. primary care and drug/alcohol services) • Services which improve access are re-opened such as drop-in and mobile clinics. • Adjustments are made for those who cannot access remote services • All care is free at the point of access • People are confident that care is confidential, and information will not be shared with the Home Office • People are given sufficient clear, comprehensible information about NHS charging 			

Issue:	Uptake of services is different to what would normally be expected	
Problems experienced by people in excluded groups	People are using healthcare services for non-COVID-19 health problems less than would normally expected	There is increased healthcare and addiction service engagement by people experiencing homelessness who are currently housed in hotels
Implications for people in excluded groups	<p>Delayed diagnosis and management of disease, poor control of pre-existing long-term conditions, reduced opportunity for health promotion and disease prevention activities.</p> <p>'Everyone in' hotels have provided some opportunities for improved health and wellbeing for PEH because of their access to secure, stable accommodation with onsite support and access to technology</p>	
Implications for provision	<p>Utilisation of health services for those experiencing vulnerable circumstances is unlikely to improve unless:</p> <ul style="list-style-type: none"> ● People have secure and stable accommodation ● Specific effort is made to increase access in groups experiencing vulnerable circumstances 	

Issue:	COVID-19 has had wide ranging implications on people's lives			
Problems experienced by people in excluded groups	Reduction and changes in many essential services has had a negative impact on many	Some children have been excluded from education and school meals	Raise in domestic violence, hate crimes and violence	Some people are more isolated
Problems experienced by people in excluded groups	People are facing eviction and homelessness	Informal and illegal workers have lost their jobs	New barriers to accessing benefits have been created	People are facing destitution, particularly those with no recourse to public funds.

Implications for people in excluded groups	People are living with uncertainty, anxiety, violence, isolation and poverty as a result of COVID-19. Many people have experienced destitution as a result of job loss, insecure accommodation, difficulties/exclusion from access to public funds.
Implications for provision	In order to reduce the negative impacts COVID-19 has on the lives of people living in vulnerable circumstances there needs to be: <ul style="list-style-type: none"> ● education provision for children without access to the internet or computers at home ● social welfare benefits that are accessible and responsive to acute needs ● protection from eviction for all (including roadside evictions) ● recognition of undocumented immigrants, and others working illegally, to allow access to social welfare in times of crisis ● action taken to end the vilification of these groups in the media ● ongoing access to refuges and places of safety for those experiencing violence

Issue:	COVID-19 and measures taken to control it are likely to disproportionately negatively impact the physical and mental health of people from the identified groups	
Problems experienced by people in excluded groups	Socio-economic disadvantages and pre-existing health inequalities increase people's vulnerability to indirect physical and mental harms	Identified groups are likely to be at increased risk of ill health from COVID-19
	Exacerbation of pre-existing mental illness and emergence of new mental health issues including reports of increased anxiety, depression, loneliness and suicide.	Quantification of the extent to which physical and mental health is impacted by COVID-19 in this group remains unknown.
Implications for people in excluded groups	Some people are experiencing poor mental health due to COVID-19. It is likely that excluded groups will continue to have negative health outcomes in the short and longer term.	
Implications for provision	To fully understand and mitigate against the negative health effects of COVID-19 for people living in vulnerable circumstances, the medium and long term mental and physical health of these groups needs to be monitored and rapidly responded to. To reduce the immediate negative health impacts on these groups: <ul style="list-style-type: none"> ● support is needed with tackling the drivers and stressors of mental health problems ● access to mental health services and alternative resources should be considered essential, with face-to-face provision facilitated where clearly needed ● services need to be responsive to the needs of these groups 	

13. DISCUSSION & LIMITATIONS

It is clear from these findings, and the ever-widening evidence base, that any description of COVID-19 as ‘the great leveller’ is untrue. Risk of exposure to the virus depends on the circumstances in which people live and work. Susceptibility to experiencing more severe health outcomes varies by age, sex, the presence of underlying health conditions, and other factors that have been identified, such as ethnicity and deprivation. The impacts on people’s health and lives will significantly depend on their circumstances prior to the start of the pandemic.

Entering the COVID-19 pandemic from a position of disadvantage

Public Health England’s rapid reviews into the disproportionate impact of COVID-19 on people from Black, Asian and BAME backgrounds and socioeconomically deprived areas are ongoing at the time of this report. The Office for National Statistics have released data showing differences in risk of death by ethnic group⁴⁷, occupation⁴⁸ and local area/ social deprivation⁴⁹. For example, this shows that, when accounting for age, Black men and women are over 4 times as likely to die as a result of COVID-19 than those of White ethnicity. People of Bangladeshi and Pakistani, Indian, and Mixed ethnicities are also significantly more likely to die a COVID-19 related death.

These social determinants and others, including immigration, housing and employment status, are known to be associated with health outcomes, with multiple factors multiplying risk. The associations of ethnicity, social deprivation and occupation with COVID-19 death seen thus far are therefore highly concerning but not surprising. At least in part, the risk of being more severely impacted by COVID-19 is likely to be worsened by the other greater risks in these groups, such as the risk of having certain underlying health conditions, or the risk of being exposed to the virus. Research suggests that these other risks do not, however, explain the entire excess risk of COVID-19 related death.⁵⁰

⁴⁷ Office for National Statistics. (2020). *Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020*. Accessed 18th May 2020 from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020>

⁴⁸ Office for National Statistics. (2020). *Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered up to and including 20 April 2020*. Accessed 18th May 2020 from <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregistereduptoandincluding20april2020>

⁴⁹ Office for National Statistics. (2020). *Deaths involving COVID-19 by local area and socioeconomic deprivation Statistical bulletins*. Retrieved 18th May 2020 from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deaths-involvingcovid19bylocalareasanddeprivation/previousReleases>

⁵⁰ Williamson E, Walker A, Bhaskaran K, et al. (2020) *OpenSAFELY: factors associated with covid-19 related hospital death in the linked electronic health records of 17 million adult NHS patients*. Retrieved 11 May 2020 from <https://www.medrxiv.org/content/10.1101/2020.05.06.20092999v1.full.pdf>

Ethnicity, occupation and social deprivation are relevant factors for the groups selected for this report. These groups have long been exposed to systemic barriers to the conditions necessary for good health and well-being. People living in vulnerable circumstances have been most affected by policies of austerity over recent years, which have increased socio-economic risk factors, while simultaneously slashing the social protection measures that mitigate their health risks.

These groups also face routine exclusion from healthcare due to barriers to GP registration, fear of and experienced discrimination and, in some cases, limited entitlement to health services. Overseas Visitor Charging has removed entitlement to free secondary care services for people without immigration status, creating an enormous financial barrier for many. It's likely the recent COVID-19 exemption will prove too narrow to alleviate this barrier during the pandemic. People still fear healthcare bills and evidence shows a similar exemption for tuberculosis is ineffective, with migrant patients more likely to have a delay in diagnosis after the NHS Migrant and Visitor Charging Programme was introduced.⁵¹

This longer-term exclusion of people from health services is likely to have disadvantaged the national response to the pandemic. At a time when everyone needed to follow public health advice and access NHS services appropriately, a subsection of the population was not integrated into the health system, many were not equipped to navigate the system, and some were too afraid to access it. The pandemic has created additional barriers reducing these group's access to healthcare and services further. Many do not have the resilience to cope with further deteriorations in their circumstances.

As COVID-19 is a new disease with new control measures, urgent proactive actions should be taken to reduce inequalities. The Government's attention on ethnicity, deprivation and other sociocultural factors on the direct impacts is greatly welcomed. Many are also looking at wider impacts on health and people's lives, and it is important that people within socially excluded groups are identified and considered from the outset. Continual rapid assessment is needed to identify and anticipate these needs and impacts so that appropriately tailored, and therefore effective, measures can be taken.

COVID-19 as a driver of destitution

COVID-19, and the accompanying control measures, has forced some in excluded groups into further poverty and destitution. Job losses or the loss of work have been common and significantly impact those working informally or without access to benefits. Navigation of the benefits system has been challenging for many without access to the internet or face-to-face support, and new destitution and homelessness has been reported, particularly among those with no recourse to public funds. Many people from excluded migrant groups often already live hand-to-mouth as a result of legislation which prohibits access to adequate financial support, such as the no recourse to public funds condition applied to many non-EEA visa

⁵¹ Potter, J.L., Burman, M., Tweed, C.D. et al. (2020) *The NHS visitor and migrant cost recovery programme – a threat to health?* Retrieved on 21st May 2020 from <https://doi.org/10.1186/s12889-020-08524-9>

holders, or the asylum support allowance which is less than 70% the rate of mainstream benefits. For people living in close proximity to destitution, the narrowing of employment opportunities and additional financial pressures, such as an increased expenditure on phone credit, caused by the pandemic, is leaving them without enough to eat or stable accommodation. Increased levels of destitution then increase peoples' susceptibility to contracting COVID-19 and presents a risk to the health of the wider population.

Digital exclusion and health inequalities

The finding throws a light on the disempowering impact of digital exclusion and its potential to be a key driver of inequality, including health inequality. It affects access to information, benefits, housing support, peer support, social contact and education, and prevents people accessing health services. During the pandemic the ability to communicate, and receive communication, is closely linked to the maintenance of good physical and mental health. The importance of phone and internet access for meaningful participation in society as well as access to essential services is an important finding when how to respond to this global pandemic and also significant for future health inequalities work as health services and access increasingly shifts to digital platforms.

Everyone In

The *Everyone In* scheme has worked well as a protective measure to ensure people experiencing homelessness who benefit from the initiative are able to practice social distancing measures safely. It has also had further indirect benefits: the report suggests increased engagement with health services as NGOs, volunteers and GP surgeries have coordinated their efforts to establish holistic provision, and an increase in the use of drug and addiction services as accommodated people have been able to progress to addressing addiction recovery as their immediate needs for shelter and food have been met. But it is unclear how long emergency accommodation, hotels or otherwise, will be available for. Many are concerned that people will again suffer the trauma of being returned to the streets after lockdown measures are lifted. The continuation of the *Everyone In* scheme also provides the opportunity to support people recently made homeless back into housing swiftly and protect them from the challenges that people experiencing homelessness long term often face. Given the rising levels of unemployment and the likelihood of a global recession, interventions like this will be key in avoiding an increase in homelessness and rough sleeping.

Although the drivers of homelessness are vast, and many are structural, the report demonstrates how a housing-first approach that prioritises stable accommodation can also address complex personal factors driving chronic homelessness, and show promising signs of success over a brief period. Now is the time to capitalise on this, by equipping those accommodated with the tools they need to find a pathway off the streets when the pandemic is over.

The impact of COVID-19 pandemic on children experiencing social exclusion

It is a limitation of this report that we have not included the child's voice. However, many of our reported findings are applicable to children from the identified groups as they are

exposed to the same lived experiences. The children from these groups are particularly vulnerable to poor health outcomes as a consequence of the COVID-19 pandemic.

The indirect impact of the pandemic has been to increase a child's exposure to adverse childhood experiences, to which children from these groups are already at higher risk.⁵² Adverse childhood experiences include experiences that cause harm directly (e.g. abuse, neglect) and indirectly as a result of household challenges (e.g. exposure to parental separation, substance misuse, mental illness, domestic violence, and incarceration).⁵³ Evidence shows that adverse childhood experiences cause adverse physical and mental health outcomes across the life-course.⁵⁴ A family's living environment including poverty, discrimination and poor quality housing can precipitate additional risk factors that in combination, contribute to poorer outcomes from adverse childhood experiences.

Limitations

The scope, methodology and context of this report lead to several limitations to the findings and conclusions that can be drawn.

As outlined in the introduction, the scope of this report was restricted to allow for a rapid and timely assessment. This meant that we were unable to cover all groups facing vulnerable circumstances. The child's voice is absent from our interviews and their experiences are relayed through the lens of their caregivers. While we can infer children within the groups included in the study share the same barriers and risk of adverse health and social outcomes as their adult counterparts, children face additional layers of vulnerability and we were not able to explore this in depth in this report. Some findings may also have limited relevance outside England, particularly where related to specific policy and legislation.

Participants were purposely selected to ensure all groups were represented. However, the rapid nature of the assessment meant not all groups had equal numbers of contributing participants, depending on their availability. Furthermore, EBEs were recruited through organisations, therefore those not in regular contact with services will be under-represented in the findings of this assessment. For example, we did not reach any participants who were in an ongoing trafficking situation.

Convenience and snowball methods were used to recruit participants which may have introduced some bias into the assessment. However, the team sought to triangulate and verify findings as far as possible to avoid the presentation of anecdotal evidence.

⁵² UCL Institute of Health Equity. (2015). *The impact of adverse experiences in the home on the health of children and young people, and inequalities in prevalence and effects*. Retrieved 18th May 2020 from <http://www.instituteofhealthequity.org/resources-reports/the-impact-of-adverse-experiences-in-the-home-on-children-and-young-people/impact-of-adverse-experiences-in-the-home.pdf>

⁵³ Hughes, K et al. (2017). *The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis*. Retrieved 18th May 2020 from <https://www.sciencedirect.com/science/article/pii/S2468266717301184>

⁵⁴ Hughes, K et al. (2017)

At the time of writing this report, publicly available data related to this topic is limited. Many organisations did not have the capacity to collect, analyse and share data from their services at this time. This has limited the team's ability to present quantification of the risks and impacts of COVID-19 alongside the findings from our primary qualitative data collection.

Finally, the findings here are highly time-specific and some may quickly become less relevant as the pandemic progresses and the challenges of these groups rapidly change. Despite this, the long-term health inequalities these groups face are unlikely to dramatically change, unless radical change is implemented.

14. CONCLUSION AND NEXT STEPS

Through this rapid needs assessment, we aimed to identify and describe the needs of routinely excluded groups, arising from the COVID-19 pandemic in England. The findings have shown that COVID-19, and the government and societal response to it have significantly impacted the health needs of these groups and widened the health inequalities they experience.

Many people belonging to the identified groups are likely to have: a higher risk of being exposed to the virus; a higher risk of health conditions that increase clinical vulnerability to COVID-19; and reduced access to and utilisation of healthcare services putting them at increased risk of COVID-19 infection and associated serious health outcomes. They are also more vulnerable to adverse impacts - as a consequence of the pandemic - on the social, economic and environmental factors that influence health and well-being. This is compounded by their experience of exclusion from mainstream healthcare services.

COVID-19 and measures taken to control it have pushed many individuals and families living in vulnerable circumstances into situations of actual or near crisis. An urgent response is required to avoid potential long-term damage to the lives of many people and prevent a public health emergency that could take decades to recover from. A cross-sector approach with prioritisation and commitment at national and local levels is necessary for successful rapid and responsive action to occur.

Where are we now?

On the 11th May, the UK government published a document called "Our Plan to rebuild: the UK Government's COVID-19 recovery strategy". This highlights plans for how the UK will continue to monitor and respond to the disease, whilst attempting to recover from its impacts and easing the restrictions on people's lives where possible. The Government cites the aim at the centre of this plan is to "return to life as close to normal as possible, for as many people as possible, as fast and fairly as possible...in a way that avoids a new epidemic, minimises lives lost and maximises health, economic and social outcomes." Our report highlights that many people living in vulnerable circumstances faced significant socioeconomic and health inequalities prior to the COVID-19 pandemic. We do not consider a "return to life as close to normal as possible" to be ambitious enough. There should instead be a 'Building Back Better' approach, using the recovery phase as an opportunity to improve on pre-crisis conditions to "maximise health, economic and social outcomes".

Building Back Better

At a time when awareness of our society's interconnectedness is heightened, and rapid alterations in policies and guidance are possible, there is a unique chance to make changes that will give everyone the opportunity to live a healthy life. There are already some examples

of positive actions undertaken to enhance inclusion during the COVID-19 crisis, including the provision of accommodation to people experiencing homelessness and the examples of good practice listed in Box 9. Steps should be taken to ensure these are sustained and built upon. With 'fairness' featuring as one of the 5 overarching principles of the UK Government's strategy, actions to reduce widening health inequalities for people experiencing the greatest levels of deprivation, disadvantage and discrimination should be high on the Government's agenda. Local governments, the NHS, PHE, NGOs, the community and voluntary sector, businesses, and wider society must work with the Government to address the needs identified in the report and together 'build back better'. Given the challenges faced by people without immigration status identified in this needs assessment, there is a clear need for these initiatives to take a human rights based approach, ensuring increases in fairness and equality of opportunity are not targeted at certain groups whilst the rights of others are weakened.

The recommendations below identify some actions that can be taken to address the needs identified in the report in both the immediate and longer-term.

15. RECOMMENDATIONS

Recommendation 1: Develop and disseminate guidance that can be understood by all people, including those with English language and literacy barriers		
Specific recommendation	Detail	Relevant organisation(s)
Establish a rapid translation hub to prioritise timely translation of all public information and guidance related to COVID-19	This should include accessible formats (audio, easy read, video). Prioritise languages commonly spoken by those where English is not a first language as well as languages commonly spoken by migrants, refugees and asylum seekers.	UK Government NHS England Public Health England
Consult with expert representatives from excluded groups in the development of guidance	Rapid and responsive consultation is needed. Inclusion of tailored guidance should be considered from the outset.	
Build trust by disseminating guidance through trusted sources	Expert representatives should be consulted to ensure that information is disseminated through the most appropriate channels and networks.	
Rapidly disseminate translated and accessible guidance to all frontline services and excluded groups	Prioritise dissemination to services who work with people who are digitally excluded. Ensure printed copies or audio recordings are made available.	
Build the dissemination of translated and accessible guidance into existing service provision	Ensure staff and people accessing services have access to the versions of guidance that are most needed.	
Recommendation 2: Ensure guidance is accessible by people without access to the internet, telephones, or other digital services		
Specific recommendation	Detail	Relevant organisation(s)
Allocate funding to address digital exclusion in excluded groups	Funding should cover access to digital devices, mobile data and calling plans, as well as training in the use of these technologies	UK Government
Increase asylum support (Section 95 and Section 4) levels in line with mainstream income support levels.	To enable asylum seekers to purchase credit and mobile data	
Provide free access to Wi-Fi within places that	This includes: <ul style="list-style-type: none"> - Initial accommodation centres - GRT sites 	UK Government Local Authorities

accommodate people living in vulnerable circumstances	<ul style="list-style-type: none"> - Home Office accommodation - Homeless Shelters - Emergency and temporary accommodation 	Asylum Accommodation providers CVS organisations
Provide people living in vulnerable circumstances with free mobile services	This includes data, credit, wireless internet and devices to use them.	Mobile service providers
Reallocate resources to prioritise supporting service users with access to technology	This may include outreach to provide mobile sim cards; training in technology; access to devices	CVS organisations
Recommendation 3: Enable people to follow COVID-19 guidance who are living in challenging and vulnerable circumstances		
Specific recommendation	Detail	Relevant organisation(s)
Release people with no prospect of removal who are being held under immigration detention powers	Given the COVID-19 circumstances, and that no removals are imminent, all detainees should be released.	UK Government
Release prisoners who are either medically vulnerable or present a low risk of harm.⁵⁵		UK Government
Consider excluded groups early in the formation of all COVID-19 related policies, and provide prescriptive guidance to organisations providing accommodation for these groups	Guidance should cover the provision of basic amenities and facilities, cleaning, social distancing, and stopping evictions.	UK Government PHE
Ensure all people in asylum accommodation have their own bedroom	<p>People should not be expected to share rooms unless housed with a spouse or family member</p> <p>This applies to those already living in asylum accommodation and those newly placed in asylum accommodation</p>	Asylum accommodation providers
Strengthen the cleaning of shared facilities and communal spaces in prisons and detention centres. Ensure reliable access to soap.	Cleaning and social distancing guidance should be observed by both staff and residents. People should be supported to self-isolate as needed.	Asylum accommodation providers Immigration Detention Centres Prisons
Provide water and sanitation facilities on all traveller sites.	Where ablutions are shared between multiple households, ensure robust procedures are in	Local Authorities Traveller site

⁵⁵ This recommendation is supported by the Howard League for Penal Reform and the Howard League Penal Reform Trust.

	place for regular cleaning and decontamination of these facilities.	managers
Risk assess all prisoners and immigration detainees for risk of exposure to COVID-19 and clinical vulnerability to the disease	Take appropriate actions according to risk assessment such as information provision and regular health checks.	Immigration Removal Centres Prisons
Increase flexibility of support provided to people to assist them to self-isolate when required	For example: enabling fortnightly rather than weekly ASPEN card top ups, offering more flexible methadone prescriptions.	UK Government
Increase asylum support levels in line with mainstream income support levels to assist asylum seekers to self-isolate when required	This would enable them to shop locally, avoiding public transport, and less regularly.	Government
Provide a guarantee that patient information collected during the pandemic will not be shared with the Home Office or used for immigration enforcement purposes	This includes information about a patient collected when accessing health service, through the shielding support scheme, home testing services or any future tracing apps or technology.	Government NHS England NHS Digital
Recommendation 4: Identify and support people living within vulnerable circumstances who need to be shielding		
Specific recommendation	Detail	Relevant organisation(s)
Guarantee that data and information collected during the pandemic, including information collected to support people to shield, will not be shared with the Home Office or used for immigration enforcement purposes	This includes information about a patient collected when accessing health service, through the shielding support scheme, home testing services or any future tracing apps or technology.	
Proactively identify and reach out to people in vulnerable circumstances who should be shielding	Use GP practice or service user lists to identify people who should be shielding. Disseminate clear and simple information to people living in vulnerable circumstances about who needs to shield, including those not registered with a GP. Use a variety of methods to ensure information on shielding reaches people including face-to-face interactions, letters, and telephone calls.	General Practices Community and voluntary sector organisations Statutory organisations providing frontline services

Conduct regular welfare checks on people in vulnerable circumstances who should be shielding	Led by primary care in partnership with other community and voluntary sector organisations when required.	DOTW
Deliver other essentials, such as fuel and gas, through shielding support services to those that need it		UK Government CVS
Permit individuals to access to Government shielding support through third parties	Those with irregular immigration status, no physical address, no NHS number or access to digital technology should be permitted to access the scheme through a third party for example CVS organisations.	CVS DOTW
Recommendation 5: Enable access to meaningful primary care for people who otherwise experience exclusion		
Specific recommendation	Detail	Relevant organisation(s)
Issue all GP practices with clear and specific guidance on patient registration, and work with practices that do not follow this guidance to reform their practices	This should include guidance on new patient registration and the limited grounds on which a registration application can be refused, and how to adapt the registration process to include those who are digitally excluded.	NHS England
Keep GP surgeries open to new registrations during the pandemic	Follow the NHSE guidance on new patient registration and the limited grounds on which a registration application can be refused. Review and adapt registration processes to ensure they enable new patients to register without visiting the practice in person or providing physical documents.	NHS England CCGs General Practices
Strengthen pathways for people who are digitally excluded or have limited access to technology to access services	Telephone services may be more accessible for people who are digitally excluded than online ones. Where possible offer face to face support and service.	
Avoid deregistering patients during the pandemic	Unless at the request of the patient	
Provide flexible options for temporary GP registrations during the pandemic		
Flag people on GP systems who are vulnerable to the impacts of COVID-19	This should include: <ul style="list-style-type: none"> - People who require a translator - People with lower levels of literacy 	

Prioritise groups vulnerable to the impacts of COVID-19 to receive face-to-face provision	<ul style="list-style-type: none"> - Those known to be living in vulnerable circumstances - People who are digitally excluded 	
Implement creative solutions which allow access to primary care for those who are digitally excluded	This should include access to new patient registration, appointment booking and consultations	
Recommendation 6: Immediately suspend hostile environment policies that prevent access to public services for migrants in vulnerable circumstances		
Specific recommendation	Detail	Relevant organisation(s)
Suspend policies and regulations that charge migrants and overseas visitors for NHS services	This should be the case for at least the duration of the COVID-19 pandemic, and then conduct a review of their impact on patient and public health before reinstating.	UK Government
Suspend NHS data sharing with the Home Office for immigration enforcement purposes	This should be the case for at least the duration of the COVID-19 pandemic.as their removal is no longer imminent.	
Produce accurate and up-to-date information about entitlement to NHS services for migrants, asylum seekers and refugees, and disseminate via trusted channels	<p>Ensure information is translated into the required languages and presented and disseminated in an accessible format.</p> <p>Consult expert representatives from excluded groups to determine best channels for dissemination of information.</p>	UK Government DOTW CVS Asylum accommodation providers Immigration Removal Centres
Issue and disseminate clear guidance for healthcare providers and staff on migrants, asylum seekers and refugees' entitlement to NHS services, charging exemptions for infectious disease, including COVID-19, and any further suspension of hostile environment policies	Communication should reach NHS frontline staff, and be regular and timely to remain abreast of any changes to the regulations	UK Government NHS England Healthcare providers
Urgently act on the ruling to lift the 'no recourse to public funds' (NRPF) condition on all visas	No one's path to regularising their immigration status should be jeopardised or delayed in the process of removing NRPF conditions from a visa	Government
Recommendation 7: Reopen outreach and drop in services for people experiencing barriers to accessing alternative services		
Specific recommendation	Detail	Relevant organisation(s)
Make funding available to support the safe re-opening	This should include healthcare but also broader support services	UK Government NHS England

of outreach and drop in services		CCGs
Classify outreach and drop in healthcare services as essential services for those without alternatives	Consider re-classification of some services from 'routine' to 'essential' if their services predominantly provide care for those living in vulnerable circumstances.	
Produce guidance to support the safe re-opening of drop in and outreach services	Guidance should provide practical support about minimising infection risk whilst still providing face-to-face support or other accessible alternatives.	
Adapt and reopen mobile clinics, drop-in and outreach services that address access challenges for people living in vulnerable circumstances.	This should include healthcare and broader support services.	Healthcare providers Local Authority CVS DOTW
Disseminate information through trusted channels about the importance of accessing healthcare and other services that are open		
Recommendation 8: Provide sustainable housing solutions for people who have been placed in emergency accommodation during lockdown		
Specific recommendation	Detail	Relevant organisation(s)
Continue to fund and provide emergency accommodation for those experiencing or at risk of homelessness	The 'Everyone In' scheme has been successful in enabling people experiencing homelessness to protect themselves and follow the public health guidance during the pandemic.	UK Government Local Authority
Provide emergency accommodation for the duration of the pandemic for people released from immigration detention centres and prison	Accommodation should be adequate to allow self-isolation when required. More sustainable housing solutions should be addressed whilst the person resides in emergency accommodation	UK Government Local Authority
Allocate funding for post-lockdown provision of sustainable quality housing solutions for people experiencing or at risk of homelessness, to ensure no one has to return to the streets.	Maintain a housing first model	
Support people experiencing homelessness with	Housing first models should be applied	

transitioning into sustainable housing solutions		
Provide timely and clear communication to people experiencing homelessness about their housing options during and after the pandemic	Communication needs to be regular, clear and accessible to assist with building trust and to reduce anxiety.	
Recommendation 9: Urgently identify and prioritise inclusion of children from vulnerable circumstances into education		
Specific recommendation	Detail	Relevant organisation(s)
Widen the definition of 'vulnerable' children to include children who are currently being excluded from education	This should include children without access to digital technology or internet; children with limited space and food; and children whose parents are less able to support their education due to literacy or language barriers. For example, asylum seeking children; children from Gypsy, Roma and Traveller communities	UK Government
Provide children in vulnerable circumstances with access to digital technology through devices or internet connection		
Urgently identify children who are currently being excluded from education for return to school	This should include children without access to digital technology or internet; children with limited space and food; children whose parents are less able to support their education due to literacy or language barriers e.g. asylum seeking children; children from Gypsy, Roma and Traveller communities	Local authority Schools
Recommendation 10: Conduct welfare checks on people in the most vulnerable circumstances		
Specific recommendation	Detail	Relevant organisation(s)
Produce updated guidance for frontline providers on conducting welfare checks for 'at risk' groups during COVID-19.	The guidance should be targeted at police, social care services, frontline healthcare providers and schools. This includes children and families living in poverty and people at greatest risk of experiencing domestic abuse and violence	UK Government NHS England
Conduct outreach welfare checks for people known to be at risk of abuse or violence as a priority		Police service Local Authority social care services

Conduct welfare checks for children in vulnerable circumstances	This should include children falling under a wider definition of 'vulnerable' discussed in recommendation 9.	Schools Children social care services
Utilise ongoing interactions with vulnerable groups as an opportunity to conduct risk assessments for domestic violence and abuse.	For example, GP or secondary care consultations.	General practices Secondary care services CVS
Recommendation 11: Strengthen destitution prevention and support for people in vulnerable circumstances or at risk during the pandemic		
Specific recommendation	Detail	Relevant organisation(s)
Extend access to public for all those facing destitution	This includes groups who ordinarily have no recourse to public funds including irregular migrants and migrants on temporary visas.	UK Government
Enable access to destitution support for irregular migrants through creative solutions	Solutions may include access to support through third parties such as CVS organisations	
Provide support to all asylum applicants during the COVID-19 crisis. Any decision that someone is not eligible for support should only be actioned after the health emergency has passed.	All new asylum applicants should be provided with secure, self-contained accommodation to allow people to self-isolate if required.	
Strengthen protections against evictions and suspend the 'Right to Rent' policy	This includes suspending the eviction of asylum seekers who are appeals rights exhausted and of those recently granted refugee status	
Increase asylum allowance in line with mainstream income support levels		
Negotiate roadside stopping points to prevent eviction of Gypsy, Roma and Traveller communities during the pandemic.	Involve the GRT community in decisions	

Recommendation 12: Actively identify evolving health and social needs of people in vulnerable circumstances and proactively develop supportive interventions		
Specific recommendation	Detail	Relevant organisation(s)
Monitor and evaluate the health impact of COVID-19 and control measures on excluded groups in the medium and long term	<p>Quantify the impact where possible. Identify any new or worsening health needs as a result of COVID-19.</p> <p>Use findings to inform ongoing actions to prevent and mitigate negative health impacts</p>	<p>UK Government Public Health England Statutory bodies Local Authorities Research Institutions and Universities Healthcare providers</p>
Horizon scan for anticipated changes in need for these groups and develop responsive plans over the medium and long term	<p>Use existing knowledge of health inequalities alongside ongoing sources of data to inform these plans.</p>	<p>UK Government NHS England CCG Local Authorities</p>
Rapidly respond to and adapt services to cater for the changes in health needs in these groups		<p>General Practices Secondary Care</p>

16. ABOUT DOCTORS OF THE WORLD (DOTW) UK

Doctors of the World (DOTW) UK runs clinics providing medical care, information and practical support to people unable to access NHS services. Our patients include refugees, people seeking asylum, people who have been trafficked, people experiencing homelessness, sex workers, migrants with insecure immigration status and Gypsy Roma and Traveller communities. In 2018, we supported over 2000 patients at our East London clinic and our case workers took nearly 13,000 advice-line calls from patients and partner organisations with health access support needs.

DOTW and COVID-19

In March 2020 we adapted our services to provide support to people through a national helpline and remote medical consultations. We continue to provide street medical outreach to people experiencing street homelessness in London and have translated COVID-19 guidance into 60 languages.

Team

This Rapid Needs Assessment was overseen by a steering committee including DOTW team members and board members. Ella Johnson, UK Senior Policy Officer was Project Lead, and Public Health specialists Dr Ahimza Thirunavukarasu, Dr Anna Ray and Dr Amy Stevens undertook the needs assessment.

Acknowledgements

DOTW UK would like to thank:

Bail for Immigration Detainees
Basis Yorkshire
Bevan Healthcare
British Red Cross
Clinks
Detention Action
English Collective of Prostitutes
Friends Families and Travellers
Homeless Health Exchange
Leeds GATE
Maternity Action
National Federation of Gypsy Liaison Groups
Pathway

Refugee Action
Refugee Women Connect
Say it Loud
Southwark Travellers Action Group
The Breakfast Club
Through the gate
Unseen
Voices of Domestic Workers
Leeds Community Healthcare

DOTW would also like to thank the following individuals for their contributions:

Rachel Burns
Abiline McShane
Dr Indrajit Ghosh
Sam Dorney-Smith
Rachel Stuart
DOTW staff

17. APPENDIX 1: Identified groups pre-existing health needs and healthcare access challenges prior to the COVID-19 pandemic

17.1 Pre-existing health needs of identified groups

Asylum Seekers and Refugees

Asylum seekers and refugees can have specific and complex health needs. These needs will be influenced by their experiences in their countries of origin, their journeys to the UK and experiences after arrival in the UK. Common health challenges include poorly controlled chronic conditions, mental health disorders and untreated communicable diseases.

Human Trafficking and Modern Slavery

People who are trafficked are likely to encounter psychological, physical and/or sexual abuse; forced or coerced use of drugs or alcohol; social restrictions and emotional manipulation; economic exploitation, inescapable debts; and legal insecurities. Many experience multiple or concurrent physical and mental health problems immediately after their trafficking experience. People are often trafficked into many forms of labour and are therefore vulnerable to a range of occupational health risks such as poor ventilation, poor sanitation and a lack of protective equipment. Exposure to multiple occupational risks can result in a range of health problems including accidental injuries and respiratory problems. In the long term, poor mental health is a dominant and persistent adverse effect associated with human trafficking.

Immigration detainees

Many people held in immigration detention have suffered torture or ill treatment and have chronic physical and mental health problems. Detention itself is associated with poor mental health and mental health deterioration over time.

Gypsy, Roma and Traveller Groups

The GRT community experiences higher infant mortality rates, high maternal mortality rates and their life expectancy is 10-12 years shorter than the national average.⁵⁶ Members of the

⁵⁶ House of Commons Committee. (2019) Tackling inequalities faced by Gypsy, Roma and Traveller communities. Retrieved 10th May 2020 from <https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/full-report.html#heading-10>

GRT community are more likely to have a long-term illness, health problems or disability, which limits daily activities or work. There is a high prevalence of mental health support needs amongst the GRT community, for issues such as anxiety and depression. Housed Gypsies and Travellers often feel isolated and in need of additional mental health support.⁵⁷

Sex workers

The health needs of sex workers are varied and depend on the particular types of sex work and circumstances in which they live. People working in street sex work are likely to experience **high** rates of anxiety, stress and post-traumatic stress disorder, resulting from a high level of exposure to violence. Chronic illnesses such as asthma, venous abscesses and recurrent chest-infections are extremely common. Drug and alcohol addiction is also very common in street sex workers. Whilst the potential for transmission of sexually transmitted infections is high amongst sex workers, research suggests that condom use has increased over the last 30 years and the incidence of HIV has decreased.⁵⁸

People experiencing homeless

Homeless people experience poorer health and shorter life expectancies than the UK average.⁵⁹ PEH often present with competing vulnerabilities including chronic physical and mental health conditions such as asthma, chronic obstructive pulmonary disease (COPD), epilepsy, heart problems, stroke and diabetes. Drug and alcohol misuse is common amongst homeless populations.

Recently Released Prisoners

People detained in prison have a significantly lower life expectancy than the rest of the population at 56 years. The standardised mortality rate of prisoners is 50% higher than the general population. This reflects the often complex health needs common to prisoners before they begin their sentence, and the disruption to diagnostic and ongoing care caused by incarceration.⁶⁰

⁵⁷ Shelter. (2008) Good practice guide: Working with housed Gypsies and Travellers. Retrieved 14th May 2020 from www.england.shelter.org.uk/_data/assets/pdf_file/0010/57772/Working_with_housed_Gypsies_and_Travellers.pdf

⁵⁸ UCL Institute of Health Equity. (2014) A Review of the Literature on Sex Workers and Social Exclusion Retrieved 11th May 2020 from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/303927/A_Review_of_the_Literature_on_sex_workers_and_social_exclusion.pdf

⁵⁹ McConalogue D et al (2019) Homeless people and health: a qualitative enquiry into their practices and perceptions. Retrieved 9th May 2020 from <https://academic.oup.com/jpubhealth/advance-article-abstract/doi/10.1093/pubmed/fdz104/5613191?redirectedFrom=fulltext>

⁶⁰ House of Commons Health and Social Care Committee. (2018) *Prison Health*. Retrieved 1st May from <https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/963/963.pdf>

17.2 Entitlement to Healthcare in the UK

Primary Care

Everyone in England is eligible to access basic primary health care. NHSE Guidance for patient registration is clear that everyone in England may register and consult with a GP, and that an inability to provide identification and proof of address documents 'would not be considered reasonable grounds' to refuse to register a patient. This guidance remains in place during the pandemic, and Primary Care providers retain an obligation to register patients living within their catchment area - including those who may not be able to prove their address or provide photo ID.

Secondary Care

Secondary care is free at the point of care to many in the UK however, under the UK's hostile environment policies, first introduced in 2015, hospitals and community services are legally obliged to charge people who are not 'ordinarily resident' in the UK. To be 'ordinarily resident' you must be a British citizen, have been granted indefinite leave to remain, or be an EU citizen exercising your treaty rights with public healthcare insurance in your home country.

The following groups of people are exempt from all NHS charges:

1. Refugees and their dependants;
2. Asylum seekers and their dependants;
3. Survivors of trafficking;
4. Children in care;
5. Victims and suspected victims of modern slavery;
6. People being treated under the Mental Health Act;
7. Prisoners and immigrant detainees;
8. Non-EEA nationals who have paid a health surcharge as part of their visa application to enter or remain in the UK; and
9. Individuals receiving section 95 support and refused asylum seekers (and their dependents) receiving section 4 support or local authority support under Part 1 of the Care Act 2014.

Hospitals and community services identify people who are eligible for charging and bill them up-front at 150% of the NHS tariff. People who cannot pay have their treatment withheld, unless it is classified as 'urgent' or 'immediately necessary' by a clinician. Patients in need of urgent or immediately necessary treatment are billed after receiving it. Unpaid NHS debts above £500 are reported by Trusts to the Home Office after two months and are used as evidence against people in immigration applications.

17.3 Barriers to accessing healthcare prior to COVID-19

Barriers migrant groups face accessing care

Primary care

In 2018, the DOTW clinic supported over 2000 patients, most of whom are living undocumented in the UK. In 1 in 5 cases, where DOTW volunteers attempted to register these patients as their local GP surgery, they were unsuccessful. Patients were refused registration by the GP for reasons such as proof of address, proof of identification and immigration status showing NHSE guidance is repeatedly poorly understood and implemented.

Secondary Care

Research from the Equality and Human Rights Commission has shown there is considerable confusion about who should be charged for what services under the NHS visitor and migrant cost recovery programme in England. Under this scheme, people can be wrongly denied 'urgent or immediately necessary' treatment that they should receive without upfront payment. Related procedures like identification and eligibility checks cause delays and deter people from using services. The UK's hostile environment policies place healthcare services out of the financial reach of people who are not allowed to work or receive most social security benefits, with evidence of lifesaving and maternity care being withheld or delayed.

Furthermore, close co-operation and data sharing between the NHS and the Home Office has made the NHS charging programme a key tool of the hostile environment. A Memorandum of understanding granting the Home Office access to NHS patient address information to support routine immigration enforcement was suspended in May 2018, but the Home Office and DHSC continue to work towards establishing a new means of sharing information and data sharing remains embedded within the charging programme. Patients with outstanding debts greater than £500 are reported to the Home Office after two months, and this debt affects the success of future immigration applications.

Barriers asylum seekers or refused asylum seekers have accessing healthcare

Guidance states that asylum seekers and their dependants should be housed in Initial Accommodation (IA) for no longer than 19 working days. In practice, largely due to shortages in housing and problems establishing destitution for Asylum Support payments, this is frequently exceeded. Applicants resident in IA and those temporarily accommodated in IA following deferral of routing are entitled to receive a healthcare service delivered by a healthcare team independent of the Home Office. There is confusion amongst housing providers around the healthcare entitlement of asylum seekers in IA. Many asylum seekers are actively discouraged from registering with a GP and encouraged to use the designated service instead. Health services are often reluctant to make referrals into the community or to secondary care on the basis that the patient 'may be moved on soon' following Home Office dispersal. In some cases, the health service or housing provider is able to advocate to

the Home Office for 'expedited dispersal', to ensure that the applicant access secondary care services more promptly, at a more permanent address.

People seeking and refused asylum often delay or evade healthcare services due to fear of arrest, detainment or deportation based on data sharing or charging debts. Concern that health conditions are taken into consideration in the asylum process, particularly conditions considered stigmatising such as HIV or mental health conditions

Healthcare professionals lack knowledge about the rights and entitlements of asylum seekers resulting in incorrect refusal of registration at GP surgeries and, in secondary care, delays or incorrect refusal of treatment.

Asylum seekers are often not provided with adequate information about their rights. Language barriers, such as the inconsistent use of interpreters and lack of translated information also impact engagement with healthcare.

Rights and entitlements to healthcare can change due to rapid and multiple changes in immigration status, leading to delays and incorrect health care refusals.

Barriers for GRT communities accessing health and social care

Primary care

There is a wealth of evidence that members of the GRT community face multiple barriers accessing healthcare. A widely reported issue is difficulty registering with a GP. Despite NHSE patient registration guidance being clear, many GRT are refused registration due to an inability to prove their identity and fixed address; an issue that particularly affects Nomadic travellers. A 2017 Traveller Movement study revealed that a third of respondents described being mistreated by reception staff and hiding their ethnicity.⁶¹

Secondary Care

Gypsy, Roma and Traveller people, especially travelling families tend to preferentially use emergency services, due to previous poor experiences, and the reluctance of GPs to register traveller patients, which impacts access to preventative medicine. Many traveller women face difficulties accessing maternity care and experience disjointed access to services.⁶²

⁶¹ The Traveller Movement. (2017) *The last acceptable form of racism? The pervasive discrimination and prejudice experienced by Gypsy, Roma and Traveller communities*. Retrieved 14th May 2020 from <https://travellermovement.org.uk/phocadownload/userupload/equality-human-rights/last-acceptable-form-of-racism-traveller-movement-report.pdf>

⁶² House of Commons Committee (2019)

Lack of ethnic monitoring within health services means that the specific needs of the GRT community are often overlooked and renders them an invisible community.⁶³ Cultural awareness and language barriers also inhibit GRT ability to access services⁶⁴

A 2019 House of Commons Committee report outlining health inequalities experienced by the GRT community found that: *While some CCGs and NHS Trusts show excellent practice in catering for the needs of their Gypsy, Roma and Traveller communities, this is often localised and fragmented. We have also heard evidence of widespread non-inclusion and, in some cases, outright discrimination.*⁶⁵

Barriers to sex workers accessing health and social care

Stigma distances sex workers from services, and many do not disclose their occupation to their GP for fear of judgement, or that this information will be shared outside of the consultation. Many Sex Workers encounter barriers to GP registration such as the need to provide their address and struggle with the telephone system for making appointments. The complex lives of sex workers also impact health service access, even where they have GPs, drug use and withdrawal make attending appointments difficult.⁶⁶ Late booking and inconsistent attendance at ANC appointments is common for pregnant sex workers; appointments, waiting times, and fear of judgement and other patients staring, are reported as significant barriers to service use.⁶⁷

Barriers to people experiencing homelessness accessing health and social care

Administrative barriers, such as an inability to provide proof of address documents, prevent many people experiencing homelessness from registering with a GP. Rough sleepers are much less likely to be registered with a GP than people living in stable accommodation. Rough sleepers who have been refused registration at a GP or a dentist have lower odds of being admitted to hospital or using an ambulance.⁶⁸

PEH access health services via A&E six times more than the housed population. They also stay in hospital three times as long. Homeless patients receive variable quality of care in hospital

⁶³ Parry, G et al (2007) *Health status of Gypsies and Travellers in England*. Retrieved 14th May 2020 from https://www.sheffield.ac.uk/polopoly_fs/1.43714!/file/GT-final-report-for-web.pdf

⁶⁴ Cromarty H.(2019) *Gypsies and Travellers, Briefing Paper*. Retrieved 10th May 2020 from <https://commonslibrary.parliament.uk/research-briefings/cbp-8083/>

⁶⁵ House of Commons Committee (2019)

⁶⁶ Stuart & Grenfell (2019) *Consultations with street sex workers in Newham, East London to inform the development of a tailored Doctors of the World health and support service*

⁶⁷ Jeal & Salisbury. (2004) *A health needs assessment of street-based prostitutes: cross-sectional survey*. Retrieved 13th May 2020 from <https://www.ncbi.nlm.nih.gov/pubmed/15284317>

⁶⁸ Elwell- Sutton, T. (2017) *Factors associated with access to care and healthcare utilization in the homeless population of England*. Retrieved 9th May 2020 from <https://academic.oup.com/jpubhealth/article/39/1/26/3065715>

and are repeatedly readmitted and discharged.⁶⁹ Many PEH benefit from the holistic support of specialist services equipped to meet their health and social care needs.

Barriers to health and social care for people recently released from prison

Recently released prisoners must register with a GP on release from prison. Often prisoners are released onto the streets making it challenging to register with a GP due to documentation and proof of address.

There can be delays in accessing needed secondary care services. For example, some mental health services will not place a prisoner on the waiting list for services until they are released from prison. With long waiting lists for mental health services there are often significant gaps in access and provision of services.

⁶⁹ The Health Foundation. (2013) *Promoting compassionate health care for homeless people*. Retrieved 9th May 2020 from <https://www.health.org.uk/improvement-projects/promoting-compassionate-health-care-for-homeless-people>

19. APPENDIX 2: Guidance for people who are clinically vulnerable

Additional guidance has been issued by the UK Government and Public Health England (PHE) for people considered to be at increased risk of severe illness due to COVID-19 disease.

Clinically vulnerable

Guidance, last updated on 11th May 2020, identifies that certain people are likely to be at greater risk of severe infection and should therefore take particular care to reduce face-to-face contact with people outside their households⁷⁰. This includes anyone who is aged over 70, is pregnant, or has an underlying health condition that requires them to get the yearly flu jab. Underlying health conditions on the list include chronic respiratory, cardiac, kidney, liver and neurological conditions; diabetes; weakened immune systems and morbid obesity.

Clinically extremely vulnerable

PHE has issued additional guidance, last updated on 18th May, for people with more severe underlying health conditions, who are classified as being at ‘very high risk of severe illness from coronavirus’, or ‘clinically extremely vulnerable’⁷¹. This includes people who have received solid organ transplants; people with specific cancers; people with severe respiratory conditions; people with severe immunosuppression as a result of disease or treatments; and pregnant women with significant heart disease.

Shielding guidance

People in these groups should follow ‘shielding’ guidance: to stay at home at all times and avoid any face-to-face contact. Specifically, this involves not leaving the house; not attending any gatherings, and strictly avoiding people displaying any symptoms of COVID-19, until at least the end of June.

People who are shielding are eligible for additional support from the government to shield effectively, for example home delivery of essential groceries and medicines. Of note, the government has advised that ‘people who fall in this group should have been contacted to tell them they are clinically extremely vulnerable’. People who are eligible should register online or by phone for receiving additional support, even if this is not immediately necessary. This includes people who have not received a letter but have been identified by a healthcare professional as having one of the listed medical conditions.

⁷⁰ Cabinet Office (2020). *Guidance on shielding and protecting people who are clinically extremely vulnerable from COVID-19*. Accessed on 19th May 2020 from <https://www.gov.uk/government/publications/staying-alert-and-safe-social-distancing/staying-alert-and-safe-social-distancing#clinically-vulnerable-people>

⁷¹ Public Health England (2020). *Guidance on shielding and protecting people who are clinically extremely vulnerable from COVID-19*. Accessed on 19th May 2002 from <https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19>