

# Community Engagement & COVID-19

A peer research investigation of the impact of the pandemic on health inequalities in Bedford Borough and Central Bedfordshire.



MARCH 2023



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**Acknowledgements: NatCen Research Team:** Eleanor O'Keeffe, Duncan Grimes, Alina Fletcher, John Evans. Zoe Wilkins. **Peer Research Team**, including: Saleha Khanom, Alcina Coelho, Ralley Rahman, Catherine Ward, Rehana Sahraouei, Jo Magill, Abeda Chand, Zara Fahr, Stephen Blaber, Gillian Bond, Stewart Shuttle, supported by Nazra Zuhyle and Paul Bragman (Community Regen). **Steering Board:** Fatumo Abdillahi, Martin Westerby, Sarah Hughes, Alexandra Wrack, Rebecca Best, Foyeke Tolani.

This research was jointly commissioned by Bedford Borough and Central Bedfordshire local authorities using funding from the Contain Outbreak Management Fund (COMF).

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Some of the Peer Research Team at the final event, December 2022.

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# Introduction

This summary report condenses the key findings of the peer research investigation of the impact of the COVID-19 pandemic on the health inequalities of residents of Bedford Borough and Central Bedfordshire. It concentrates on the experiences of those residents we know to have been disproportionately impacted by COVID-19, analyses why this was the case, and makes suggestions for what might improve outcomes in the future based on the insights and suggestions of the participants themselves.

The research was commissioned by Bedford Borough and Central Bedfordshire local authorities as a community engagement initiative to address health inequalities in these two areas in response to the COVID-19 pandemic. This recognises the role of inequalities in deciding unequal pandemic outcomes across the population, as well as the centrality of community participation to co-developing solutions to these issues.<sup>1</sup>

NatCen, a national social research agency, worked in partnership with community consultancy specialists Community Regen to develop the project with disproportionately impacted communities. The project was grounded in peer research methods to mobilise knowledge from these communities and create a dialogue from which solutions could be co-developed. We worked with peer researchers to design a multi-methods approach to generate insights into how these communities had been impacted by the pandemic, why this may have taken place, and what policy or service solutions might improve outcomes for them in the future.

## 1.1 A community engaged approach

### Peer Research Design

This project used peer research methods to identify and examine the experiences of disproportionately impacted communities in Bedford Borough and Central Bedfordshire. We aimed to recruit peer researchers from specific ethnic minority communities, people residing in areas with high levels of deprivation, or front-line health workers within these two local authority areas.

Community Regen and NatCen ran a community-based recruitment campaign, advertising in local community spaces (e.g., sports centres, libraries, places of worship), at local events (e.g., Eid festivals), and through local social networks, to invite people from communities affected by COVID-19 to become peer researchers. After an informal process of selection, 13 peer researchers (out of 32 applicants) committed to the project. NatCen devised and conducted a training programme in research design, methods, and practice to support these peer researchers to contribute to decision-making about the survey and focus groups as well as preparing them to

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<sup>1</sup> This is increasingly recognised as a useful and important aspect of recovery from the COVID-19 pandemic. E.g., Toynbee Hall & Thrive LDN, *Pandemic Stories: A Participatory Action Research project exploring the experiences of Londoners disproportionately affected by the COVID-19 crisis and their policy recommendations for a fairer future for all*. August 2021.

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take the lead in delivery. Through co-analysis sessions with the NatCen team, the peer researchers also contributed to the analysis of the evidence generated.

The peer researcher team included people of Central and South Asian (Bengali, Pakistani, Afghani) and Middle Eastern (Iranian) heritage, as well as others from White European and Australasian (New Zealand) backgrounds – seven of its members lived in Bedford Borough and six were from areas across Central Bedfordshire. We recruited one researcher who had experience of working in front-line health prior to the pandemic, and another two researchers from older age groups who were also disproportionately impacted by COVID-19.

### **Reaching communities disproportionately impacted by COVID-19**

Working with the peer researchers, we developed a strategy to support people from communities disproportionately impacted by COVID-19 to share their experiences. We planned two routes for community engagement – a survey, which invited everyone in the community to contribute to a study exploring health inequalities during the pandemic; and focus groups, which allowed us to concentrate on our priority groups including ethnic minority communities, people residing in areas with higher levels of deprivation, and front-line health workers. The survey was shared through community and local authority social media channels. Peer researchers helped raise awareness and interest in this project amongst their communities.

This balance of inclusive and more targeted approaches allowed us to appreciate the nature of disproportionate impacts experienced by some communities by contextualising these within a range of impacts identified by the wider population. This brought other difficult experiences to light, which has given us a better understanding of the pandemic's impacts across communities in Bedford Borough and Central Bedfordshire.<sup>2</sup>

## **1.2 Multi-method design & achieved sample**

### **Routes to engagement**

Peer researchers helped us to design and build routes for participation that would encourage people from these communities to share testimony in ways that were comfortable for them. In addition to Likert scale questions about what services, support, or communication they had accessed during the COVID-19 pandemic, we asked people to share their experiences of COVID-19 impacts or identify gaps in support through open questions and invited respondents to use their own words in free text boxes. The focus groups ran between 2.5 and 3 hours with a limited number of participants in each, to give people the space they needed to share what had been, in many cases, difficult experiences.

### **Breakdown of Responses: Bedford Borough & Central Bedfordshire**

Our survey received 811 responses – 83% of respondents resided in Central Bedfordshire and 17% in areas within Bedford Borough – and 71 people shared their in-depth reflections on the impact of COVID-19 via 10 individual focus groups. The numbers of focus group participants from Central Bedfordshire and Bedford Borough were roughly equal.

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<sup>2</sup> The project also produced a Source Book, which contains a summary of the wider evidence and community insights gathered from the wider population during the project.

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## Community Participation

### *Ethnic minority communities*

We received 72 responses to the survey from people who self-identified as belonging to ethnic minority communities, with the majority (53) from South Asian communities and a smaller sample from Black African and Black Caribbean communities (19).

Building from the networks of the peer researchers, we held six focus groups to gather and record experiences from Black British (Black African, Black Caribbean) and South Asian communities in Bedford Borough (British-Indian, Bengali, Pakistani). Most of our focus group participants from ethnic minority populations resided in areas around Bedford Borough (80%) compared to areas in Central Bedfordshire (20%). For South Asian communities, we held focus groups for women and men separately, so the differences in experiences by gender could be better understood

### *Participation from areas with higher-than-average levels of deprivation*

We received 91 survey responses from people who resided in wards with higher-than-average populations in the top two deciles of deprivation (IMD 2019) – e.g., the more deprived wards in these local authority areas. Roughly 50% of our focus group participants resided in these targeted wards, with high levels of representation from Kempston North and Kingsbrook. Of the respondents residing in areas with higher deprivation levels, slightly more (55%) came from Bedford Borough than Central Bedfordshire (45%); although our Bedford Borough survey participation was lower overall, it was drawn more from areas of deprivation.

We found significant overlap between respondents from ethnic minority communities and those who resided in areas with higher levels of deprivation amongst the population. For instance, 34% of respondents who identified as coming from South Asian communities resided in areas with higher deprivation levels.

### *Front-line and health workers*

We used a wide definition of what constituted a front-line worker, acknowledging the various occupations recognised as ‘critical workers’ in the pandemic, such those who worked in social and health care, the justice system, food production etc. Due to peer researcher availability and health issues within the fieldwork period, however, we were not able to carry out the focus groups scheduled for drug and alcohol support groups and warehouse workers as planned. We held one focus group for front-line health workers, supplementing this with relevant participant testimony from other focus groups. The survey has also proved a rich qualitative resource. Not everyone chose to record their occupation, but a few respondents reflected on their experiences as factory or warehouse workers, which we have drawn on in this report.



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### 1.3 Reporting the findings

These routes generated a significant body of qualitative evidence through which to analyse impacts of the COVID-19 pandemic on health inequalities in Bedford Borough and Central Bedfordshire. We used descriptive techniques to analyse the survey and comparative analysis (where possible) to establish commonalities or differences between population groups. We employed qualitative thematic analysis to study the free text responses, which enabled us to identify community patterns of responses in relation to COVID-19 impacts. The testimony from the focus groups allowed us to clarify or qualify the findings drawn from the survey, offering specific, person-centred, and community-level insights into the pandemic's impacts, past and present, from the perspectives of people who had been disproportionately impacted by COVID-19.

Our findings are drawn from both sources (survey and focus groups). Whilst we acknowledge the survey analysis throughout the report, we offer testimony from participants to illustrate the important features of community experience we identified. In selecting quotations, we have chosen to include those which represent views we commonly saw across disproportionately impacted communities across the different local authority areas.

The report recognises that there are multiple factors and intersecting social and health inequalities behind the COVID-19 disparities that were the focus of this research. We acknowledge the crossovers between populations, such as residents living in wards with high levels of deprivation, those from ethnic minority communities, and people who worked in front-line roles. We flag where and how other social determinants of health or co-factors related to health inequalities created an additional layer of negative impacts for some people, e.g., for reasons of age, gender, or chronic health conditions.



Peer researchers during the survey dissemination, June 2022.



Peer Researcher training session, Flitwick, Central Bedfordshire.



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# 2. Impacts on Health Inequalities

## 2.1 Increased vulnerability and risk

“We got to a point it was like, oh, my God, we're going to get a phone call/a text. Anybody. Anybody from the community. There was no like, 'Oh, it'll be the elders because they're ill.' It was that anxiety; like anybody could go.” – Female, 36-45, British-Pakistani.

An increased risk of infection and death defined the experience of the pandemic for many of the participants from disproportionately impacted communities who engaged with this study. Our survey showed that many people from Bedford Borough and Central Bedfordshire were badly affected by societal lockdown: most people, for instance, listed the struggles resulting from isolation from family and friends as the major impact of the pandemic. But participants from ethnic minority backgrounds (of all ages), front-line workers, and those residing in areas with higher levels of deprivation, shared a level of anxiety and awareness of their increased vulnerability that was otherwise mainly seen in the older age groups of the white population or people with long term or chronic health conditions.

The social realities of disproportionately impacted communities in the pandemic, as this report shows, created a heightened awareness of social disadvantage and ongoing anxiety about its effects on their lives. As the following evidence demonstrates, the fear that came from rising infection rates, death tolls, media representation, the lack of trust in government systems, and limited agency, had consequences. Some people resigned from front-line health positions; some avoided GP surgeries or hospitals; some felt prevented from helping others. It explains, too, the disproportionate toll the pandemic took (and continues to take) on mental health. But vulnerability to the virus also created the context and spur for collective action, which has generated a renewed belief in community cooperation and the possibility of social change.

### Experience of deaths in the community

“I remember at one point, it was like for I think two or three weeks, every single day I'd hear funeral - this person's funeral prayers, that person's funeral prayers, every single day - and it was always Asians.... Muslims.” – Male, 20s, British-Pakistani.

Many participants in our study from ethnic minority communities referenced knowing people in the community (friends, family, acquaintances) who were hospitalised or had died from (or during) a COVID-19 infection. This was far less common in the white population who engaged with the research. In the survey, the proportion of

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South Asian respondents who identified 'bereavement' as a community impact, for instance, was far higher than seen in relation to 'White British' cohorts. More focus group participants from Black and South Asian communities described multiple bereavements from COVID-19 within their close family and community networks. Other participants from these communities described the feeling of COVID-19 tearing through their communities, as hearing about deaths or hospitalisations became a daily occurrence.

### **Recognised factors driving infection**

**"I was watching the news and seeing people young die - people my age. We knew a couple of people who were my age who died, so it was quite scary being on the front-line, especially with my job." – Female, 26-35, Black British Caribbean.**

Participants reported that many people in ethnic minority communities (South Asian, Black African, or Black Caribbean communities) had not taken COVID-19 seriously at first, which they thought led to higher infection rates amongst communities with larger families and with an active community life. But participants also identified that at least part of the problem stemmed from a higher proportion of front-line workers from within these communities, as well as the greater prevalence of people in lower paid or more junior positions. This meant they were often more exposed to the virus and had less agency to make decisions to protect themselves, either because they had no economic reserves to fall back on (they needed the money) or because their voice didn't count with their employers. Some described being moved to front-line positions in health without consultation; they were not given the option to furlough and saw no alternative because they needed the income.

**"As a key worker, even if you didn't want to go, you felt forced to go to work. Otherwise, you would lose your job, you would lose earnings... it was just a lot of stress, a lot of fear, and there was nothing really you could do." – Female, 46-55, Black-British.**

### **Increased stigmatisation: language of media and guidance.**

Participants referenced media coverage and governmental guidance that highlighted the higher risk of infection and death from COVID-19 faced by ethnic minority communities but did not also unpack the reasons for that risk. This meant that transmission became inferred as racialised, rather than explained through social health inequalities. Other studies have highlighted how media coverage and guidance contributed to increased stigmatisation of people from ethnic minority communities and those working in front-line health roles.<sup>3</sup> A few of our participants encountered similar challenges: those who worked in front-line roles, particularly, felt watched by their neighbours. But, as the adjacent testimony suggests, participants also worried about how people internalised these messages and their corrosive effect on people's wellbeing and their sense of belonging to the wider community.

**"You can even begin to [think], 'Am I the wrong race? Why me?' ...I know that [it's] for statistics and all sorts of reasons, but I think sometimes, there is an unnatural negative focus on race." – Female, 66-75, Black African-British.**

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<sup>3</sup> See 'Feeling Targeted' in [https://m.luton.gov.uk/Page/Show/Health and social care/coronavirus/Pages/talk-listen-change-executive-summary.aspx](https://m.luton.gov.uk/Page/Show/Health%20and%20social%20care/coronavirus/Pages/talk-listen-change-executive-summary.aspx).

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## **Threat to community capacity and erosion of social bonds**

“You were afraid to reach out. You’re afraid that maybe you approaching them is actually going to make them feel more scared or put them at risk. It made you withdraw more from the community rather than reaching out.” – Female, 36-45, African British.

People from all population groups in the survey recorded how isolation from family and friends had badly affected them during lockdowns. Participants from ethnic minority communities, however, were particularly impacted by lockdown regulations because they relied on wider and more complex social networks and found it harder to return to ‘normal’ because of their sense of vulnerability. Helping neighbours, or getting involved in community schemes became harder, or a matter of considerable courage, during the pandemic.

For participants with larger families who were mainly, but not exclusively, drawn from South Asian or Black British backgrounds, social isolation was deeper and longer lasting because of fear of infection within these communities. Travelling overseas to visit extended family became too difficult and costly with the testing and regulations. Participants reported that they still (at the time of the research) missed out on seeing family and friends - nearly a year after all social restrictions had been lifted in the UK – because of the continued risk.

The closure of places of worship also impacted ethnic minority communities more than other population groups. The significance of places of worship – whether church, temple, or mosque – to the wellbeing of participants cannot be overstated. Some participants reported that their faith communities had remained open as far as they could, or went online, but others said this was not a universal experience. For some Muslim participants, that important festivals such as Eid or Ramadan were not ‘saved’ by the government as Christmas (2020) had been ‘saved’ was an ongoing source of grievance.

## **2.2 Exacerbation of health inequalities**

“Because they were not earning, people started picking up debts. Those who already had debts, because they weren’t working, they also had debt defaults.” – Male, 46-55, Black African British.

### **Heightened economic insecurity**

People who began the pandemic in precarious working conditions, another dimension of social health inequalities, were more vulnerable to COVID-19 impacts. Respondents to our survey who resided in areas with higher levels of deprivation or who were from ethnic minority communities more commonly identified household financial struggles as a major impact of the pandemic, due to loss of jobs, inability to work, or reduction in household income from the furlough scheme. Whilst the wider population listed ongoing impacts relating to closure of local businesses or the state of local high streets, it is striking that those from deprived communities spoke more about people they knew getting into debt, defaulting on loans, and needing to use food banks.

For some communities, where there was a significant portion of the community working in travel, transport, or hospitality sectors, these economic impacts were experienced as community impacts. Respondents to the survey, for instance, identified how taxi drivers from South Asian communities had been particularly badly hit during the first wave of lockdown. But some people felt they had to choose economic insecurity over the risk of working in a front-line position. One focus group participant, a health worker, described how she managed her risk in her role, even though she was the sole breadwinner in her family:

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“The ‘What if?’ made me leave the job. I couldn't cope anymore. I said to myself, 'Is it right I carry this home and kill these three children?'" – Female, 36-45, Black African.

### **Impacts on families: lack of space, time, and resources**

Whilst all families suffered impacts from lockdown restrictions and the closure of schools, participants from ethnic minority communities and people with low household income, particularly those with large families, felt their children suffered poorer outcomes from cramped housing conditions, and the lack of resources for learning at home. These participants had to limit broadband use, either due to cost or to prioritise earning over their children's education. Others had to leave children unmonitored for long periods of time, whilst working. Children from ethnic minority communities or from key worker families were also particularly aware of the increased risk of the virus; anxiety for their parents impacted on their emotional wellbeing and mental health. Parents in these communities shared that their children developed a form of anticipatory grief, believing their parents would die, and displaying symptoms of anxiety when returning to schools where the virus was circulating.

“We were all locked together in a home. It was a sad time for the kids to have that. For us as the parents as well, to go through that was difficult.” – Female, 36-45, British-Pakistani.

### **Women and domestic labour**

Our analysis of the survey and focus group responses suggest that domestic labour fell unequally on women during the pandemic, and especially so for women with large families, many of whom had to manage their children's education and wellbeing alone. Many, but not all, of these participants were from Black (Black African/Black Caribbean) or South Asian backgrounds; there were lone female parents from white backgrounds who resided in areas with higher levels of deprivation in Bedford Borough and Central Bedfordshire, for instance, who were the sole carers of 3-4 children. They also shared that the pandemic had been a period of unrelenting work and acute stress.

For these women, the increased domestic labour had continued well beyond the lifting of regulations in July 2021. At the time of the research (June to September 2022), they were still focused on undoing the damage resulting from the pandemic, sometimes describing their children as risk averse, introverted, or suffering from a range of mental health complications. Reintegrating children into social life – a task that fell to them – created additional emotional and actual labour for these mothers, especially for those who depended on play groups for childcare, or those who came from communities with extended kinship networks and obligations. They shared that that it was especially difficult to balance children's health needs with societal and cultural expectations, as this mother who was dealing with her young child's anxiety describes:

“In Pakistani families it's so hard to tell your elders, 'Please don't go near to my child.' It's considered to be very rude. That was another stress on my mind that I am being very disrespectful in my family and that people are thinking that staying at home made us rude people.” – Female, 26-35, British-Pakistani.

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## 2.3 Health impacts

“I find the impacts of social isolation on mental wellbeing are long lasting. It doesn't help that COVID is still around and can be dangerous, but we are not having any safety measures in place so there is anxiety in the back of [my] mind.” – Female, 26-35, British-Pakistani.

### Mental Health Impacts

Mental health impacts were the most frequently identified health impact in our survey, demonstrating adverse impacts on the community at large. But responses were particularly pronounced amongst communities we know have been most impacted by the pandemic and who were more at risk from the virus and/or its social and economic effects. People with long term health conditions who were placed in high-risk categories (and may have already had poor mental health), found these conditions worsened due to concerns over their increased vulnerability. As society opened up, their sense of social isolation has only increased.

Participants from ethnic minority communities, and front-line health workers, however, recorded mental health impacts to degrees beyond those seen in the rest of the survey cohort, resulting from heightened risk, unrelenting working conditions, and feelings of powerlessness. Mental health impacts were pronounced for South Asian respondents in the survey but other ethnic minority community participants in the focus groups also referred to the widespread bereavement in the community and the disruption to normal grieving rituals.

“I have blood cancer. I have been shielding for 2 ½ years. There is no community for me. The impact on my life has been huge, physically, and psychologically” – Female, 46-55, White British.

“The loss of a lot of lives in our community - That affected people's mental health a lot – they weren't able to mourn as they wanted to, [to] grieve together.” – Female, 36-45, Pakistani.

### Reduction in health seeking behaviour

Media coverage of the levels of deaths in ethnic minority communities, and participants' own experiences of hearing about friends or family members going into hospital and not coming out, led to a reduction in health seeking behaviour. People from these communities became hesitant to seek support for health conditions. Some focus group participants from these communities described how their friends and family began to see hospitals as dangerous places, even as 'death traps'. Their worries increased as behavioural interventions ceased, guidelines relaxed, and people were left to make their own choices. It became hard to trust that hospitals and GP surgeries were safe.

“I can't just go to the doctor because they're... I'm still scared of accessing health support because I just think - is all the COVID removed from the hospitals?” – Female, 46-55, Black British.

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### Health choices in lockdown

Our study captured very different experiences regarding the health impacts of the pandemic. Some participants, as the adjacent testimony suggests, found a renewed sense of wellbeing from time spent with their family; they established new habits of outdoor exercising, or connected with fitness groups or support groups online. With these changes came increased confidence and more positive outlooks. Resources, however, mattered. Reduced income limited the ability of some participants to meet basic health needs through a varied diet. This resulted in ongoing negative impacts which some participants continued to struggle with.

“I learned how to cycle. I didn't know how to cycle. It was in my bucket list, and I did it because my daughter later taught me how to cycle.” – Female, 36-45, African-British.

“We ended up eating unhealthily, leading to obesity, so our health has been affected. It's not like you had a choice. Lack of funds, again, because you just had to buy whatever you could to survive in the house.” – Female, 36-45, Black African.



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# 3. Access to Services, Support, and Information.

## 3.1 Accessing support and services

We asked people to share in the survey and focus groups what support systems they relied on or used during the pandemic to see if there were differences between access levels in the population and unmet needs. From the analysis, we found that there were quantitative and qualitative differences between disproportionately impacted communities and the wider population in what kind of support and services they accessed, especially in the following areas:

### Community Support and Local Community Groups

Reliance on local community groups was one of the most strongly differentiated features of the survey for ethnic minority communities. Ethnic minority respondents and people residing in areas with higher levels of deprivation were more likely to report relying on 'a lot' of support from, 'local community groups': 43% of Asian respondents, for instance, and 56% of black respondents, reported relying 'a lot' or 'some' support from this source, compared to 22% of respondents who identified as 'White British'.

The survey did not ask participants to detail what kind of groups they connected with. From the focus group discussions, however, we found that some people from these communities relied on the community voluntary networks, supported by social media (e.g., 'Leighton Buzzard helpers'), which drew people together from across Central Bedfordshire and Bedford Borough. The importance of faith groups and places of worship, both for practical support and emotional wellbeing, was also clear, as well as the ways in which parents relied on playgroups and other childcare support to help balance their childcare needs and for their children's health and happiness.

"I think we've got a good network of people, and especially as a focal point, our masjid, our mosque. In any times of difficulty, I find the community gets together. There's always someone there to help." – Female, 36-45, British-Pakistani.

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## Neighbours

Nobody came to my house. Nobody said, 'I see you're a single parent, with four children, and you're working for the NHS. Would you like some help?' – Female, 36-45, White British.

The ways that people came together to help neighbours and others on their street has gone down in national memory as one of the more positive aspects of the pandemic.<sup>4</sup> Participants from ethnic minority communities also reflected on this greater community cooperation and believed that getting to know people who lived nearby, helping people, and being helped in turn, was a significantly positive outcome of the pandemic.

From those who responded to our survey, there were differences evident in access to neighbour support, which may have been connected to health inequalities. People who were younger, and especially younger people from ethnic minorities, were less likely to report accessing neighbourly support. This might, of course, reflect lower levels of need or lower vulnerability, but our focus group testimony demonstrates that this was not always the case, especially for those residing in areas with higher deprivation or people with larger families. Parents, for instance, described wishing for help in meal preparation or shopping to alleviate the intense domestic labour the pandemic engendered. They did not often report getting this help.

Societal expectations and representations of vulnerability may have disadvantaged some people and made it harder for them to access help that otherwise became more substantial, systematised, and widespread during the pandemic. The needs of elderly people were clearer to their neighbours. Other needs were less visible and perhaps harder for people to address, e.g., lone parents with large families, or new parents or families caring for the elderly in multi-generational households.

## Council support

Our survey population did not access much support from their local council during the pandemic, although we can see how people with specific needs relied on council support during this time. Carers, for instance, reported that they accessed high levels of council support; in the focus groups, many people in the older age groups (such as over 65s) described feeling safer due to welfare calls instigated by local councils, although they sometimes did not know who these were from. People residing in areas of higher levels of deprivation recorded slightly more engagement with council support systems: 14% compared to 10% in other areas said they had accessed a lot of support from this source.

From the focus group testimony, participants from ethnic minority communities did not have homogenous experiences or clear views about council support during the pandemic. Some of our participants shared that they relied on council support particularly in the first wave: one young father, from the South Asian community in Bedford Borough, with a new baby at home, described the care packages he received, which included nappies and essentials such as bread and milk, as a 'lifeline' because it was so difficult to leave the house.

**“Help wasn't pronounced enough to many people to know that the help was there in different forms. People end up saying there wasn't any help.” – Male, 46-55, Black African-British.**

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<sup>4</sup> The UK Commission on COVID-19 Commemoration is tasked to determine 'how the national spirit through which everyone played their part should be celebrated', for instance. See <https://www.gov.uk/government/organisations/uk-commission-on-covid-commemoration/about/terms-of-reference#objectives>.

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But some people were less aware of what councils did during the pandemic. Those who referenced community schemes, for instance, did not appreciate that these may have had council backing. When people did not know about services, or had not been contacted directly, they tended to assume that no help was available. In the survey, for instance, there were several comments like ‘council left us alone without resources’ that were unspecific and reflected a general feeling of being unsupported. Some recognised that much had been done by local authorities, but there were communication barriers, which might have prevented people from identifying services relevant to them.

### Health services

Most respondents to the survey did not report high levels of access to health services during (perhaps due to) the pandemic. Our survey found that ethnic minority communities and people from areas of higher deprivation did not necessarily differ in their levels of access, although respondents from higher deprivation areas in Central Bedfordshire, for instance, seem to have reported slightly less uptake in this respect.<sup>5</sup>

Even if the levels of uptake of health services were roughly the same, the experience of health services was different, however, for those from ethnic minority communities. During the focus groups, participants reported their worries over visiting health services due to the risk from the virus, which has been detailed earlier in the report. In addition, some participants reported feeling more discriminated against in health care during COVID-19, which they felt was linked to assumptions about the spread of the virus in these communities. One participant remembered visiting maternity services during lockdown: her husband was asked to leave the building, whereas white partners were invited to remain in the waiting area.

“As a Pakistani and a Muslim who’s got a hijab on, there is one rule for one and one for another.”  
– Female, 26-35, British-Pakistani.

### Employer support systems

Employer support was one of the most significant sources of support for many people during the pandemic, either through the furlough scheme or implementation of more flexible working systems (e.g., work from home). This was second only to neighbours in the survey – over 70% of employed people recorded that they accessed support from their employers. Whilst this support was not perfect (and some felt that the furlough system was implemented unfairly by employers), for most people employers provided a vital form of help at a time of considerable uncertainty.

Reflecting greater economic insecurity, respondents from ethnic minority communities were far less likely to record this as a source of support in the survey: only 33% of Asian respondents accessed a lot of support from employers compared to 64% ‘white British’, for instance. This reflects the ways in which patterns of work and occupation within communities also impacted on the support people were able to access and the help they received.

### Unmet needs

We asked participants to outline what services or support they would have liked to have accessed but could not. For most survey respondents, this elicited a general dissatisfaction with current access to GP services, which

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<sup>5</sup> 15% of respondents from areas with higher levels of deprivation recorded ‘a lot’ or ‘some’ access compared to 24% for other areas of Central Bedfordshire. But small sample must be considered and there is little evidence from the focus groups that can help us gain clarity in this area.

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may reflect the broader public conversations happening at the time of the survey collection (June 2022) rather than community-level experiences. Focus group participants, for instance, shared some very positive experiences of their local surgeries as well as more challenging ones. Unmet mental health needs, and the necessity of better support, particularly for children and young people's mental health and wellbeing, was also a recurrent theme for respondents from ethnic minority communities and those residing in areas of higher deprivation.

## **Vaccines**

We identified differences in attitudes towards vaccination between participants from ethnic minority communities, those residing in areas of higher deprivation and the wider population. People from these groups reported that they were less convinced that the vaccines were safe, although they largely did not share their reasons for these views in the survey. In the focus groups, however, participants referred to factors such as cultural barriers and historic suspicion of public health programmes, which other research has highlighted as formative in vaccine hesitancy.<sup>6</sup> Some participants from ethnic minority communities also shared that public health campaigns seemed pressuring, relentless, and unhelpful. Some felt forced into getting the vaccine against their judgement and still worried about possible effects that might arise in the future.

**“I’m scared of the bloody things anyway; they gave me no choice. It was scary enough going through what we were going through. They gave me no choice. They were just so persistent.” – Female, 36-45, British-Pakistani.**

## **3.2 Information access and communication needs**

Recognising that health choices in the pandemic depended on access to information, we asked people to share what sources of news and information they relied on. Whilst the views of disproportionately impacted communities aligned with the wider population in many important ways (i.e., preference for the NHS as a trusted news source over national government), we identified some pronounced differences, which affected how people accessed information and what kinds of information they received about the pandemic.

### **Reliance on family and friends’ networks**

People from ethnic minority communities and those residing in areas with higher deprivation levels were more likely to rely on friends and family as trusted sources of news during the pandemic, although this was in general the more popular communication channel for other residents of Bedford Borough and Central Bedfordshire. 74% of respondents residing in areas of higher deprivation in Bedford Borough and 83% from Central Bedfordshire, for instance, compared to 59% of respondents residing in other wards in Bedford Borough and 65% of respondents from Central Bedfordshire.

### **Misinformation and cultural barriers**

**“My mum – she doesn’t speak English. She just sees what’s on the news on Bengali news, and sometimes I remember her saying, ‘Don’t worry, it’s not – it doesn’t exist.’” – Male, 20s, British-Bangladeshi.**

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<sup>6</sup> E.g., [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/952716/s0979-factors-influencing-vaccine-uptake-minority-ethnic-groups.pdf)

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Participants felt that people from their communities trusted information from their close community circles, but this also made them more vulnerable to misinformation that spread quickly via social media influencers or via news channels from outside the UK. People, particularly the elderly, did not always get the right information when they needed it. Younger participants from ethnic minority communities reported trying to bridge the divides between public health systems and their relatives, imparting guidance, and information to them directly, but they faced considerable challenges in this respect.

### **Language in guidance and official communications**

Another reason that people identified for the lack of access to effective public health communication was the language of guidance and official communications, which was convoluted and overly technical for people for whom English was a second language. The participants who raised this in our focus groups were highly proficient English speakers who used English in professional contexts – if *they* couldn't grasp the subtleties of pandemic neologisms, such as 'lockdown' or 'social distancing', they asked, who else could?

**“The word ‘lockdown’ – I’ve never seen this word before, it’s not in my primary language. I didn’t know what it means...lockdown could be anything.” – Female, 36-45, African-British.**

### **3.3 Feeling part of the community in Bedford Borough and Central Bedfordshire**

Community – what that meant, and how it had changed, during the pandemic – was an ongoing theme of discussion in the research. Whether people talked about impacts of COVID-19, support mechanisms, or access to information, they often reflected on how the pandemic had inspired greater cooperation and brought people closer together. For many people, the pandemic has been a positive force in helping to cement community relations. A greater 'community spirit' was the most significant theme identified as an 'ongoing impact' of COVID-19 in our survey.

Ethnic minority participants in this study, however, displayed a greater ambivalence when it came to the growth in 'community spirit'. On the one hand, all our focus groups contained positive conversations about how people had helped each other during the pandemic. Some also pointed to the significant voluntary efforts of Christian (e.g., New Black Majority Churches) Muslim, Sikh, and Hindu faith communities, to care for their communities and others, believing that this provided positive societal exemplars for their communities.

Despite this, people from ethnic minority communities were less likely to cite the growth of a 'community spirit' as a lasting impact of the pandemic. This may be because the pandemic had illuminated inequalities in how people live in the UK; as participants reflected in the focus groups, it created new venues for racial discrimination and eroded a sense of belonging as fast as it nurtured it. Whilst 'White British' respondents could be convinced that 'community spirit' had been achieved, people from ethnic minority communities saw the cooperation seen in the pandemic as a first step in this direction, which should be followed by a sustained societal effort to which everyone (communities, councils, government) must contribute.

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# 4. Identifying and Developing Solutions

## 4.1 Identifying solutions for change

We asked participants to identify areas for change that might make a difference to their lives now or in future crises. Each focus group discussion ended with an elicitation exercise to establish what 'recommendations' they might make to each of the councils to improve their experiences or produce better outcomes. The NatCen team then undertook two co-analysis sessions in October 2022 with the peer researchers to collate and group these suggestions for a co-production workshop a few weeks later.

This next stage of the project aimed to engage local authority and NHS representatives to strengthen the solutions identified from within communities, so they could be translated into council work or applied in local authority contexts. A key challenge we faced was that study participants and peer researchers were not aware of the entirety of services and support systems that had been put into place during the pandemic and which organisations had developed the services. Understandably, they sometimes had incomplete knowledge of how local authority or NHS systems work. This made it difficult to identify realistic recommendations and they sometimes listed structural changes as solutions (e.g., 'fund the NHS').

The Co-Production Workshop brought the research team (NatCen, Community Regen, Peer Researchers) together with councillors, and local authority staff, public health officers, NHS colleagues and representatives from local health systems. We shared findings from the project and engaged in discussion with workshop participants to gain feedback to help us strengthen initial recommendations. We benefited from ongoing feedback from the Steering Board and the Senior Management Team, which has also helped refine the recommendations from participants that we have published in the report.

### Lessons from Co-production Workshop

The workshop reflected our ambition to undertake a meaningful process of co-production between citizens from disproportionately impacted communities and local authorities to identify strategies or policies that might help them in the future. Acknowledging that this process cannot be completed in a single workshop, we share lessons learned from this enterprise that can inform future efforts.

- **Widen participation.** The experiences highlighted in the project are relevant to a wide range of local authority and NHS partners in the wider system, as well as community engagement, communications, and environmental health teams.

- **Ongoing discussion.** The scope of these recommendations, which related to a wide range of work specific to the local authority and NHS partners, demanded a longer, ongoing process of discussion and reflection, which cannot be achieved in a one-off event.
- **Time to engage with testimony.** Local authority representatives found the peer researcher’s reflections very powerful. They wanted time to sit with the evidence, and hear the testimony shared with the project, to build understanding of the issues local communities faced.

#### 4.2 Recommendations from participants

This co-production process shaped the recommendations we have published in this report. We used the breakout room and plenary recordings and elicitation materials created during the co-production session to refine the recommendations made by the participants in the study, whilst keeping the original sentiments. Sometimes we have made modifications based on the advice we received from those who attended the co-production workshop: e.g., we have acknowledged where gaps identified may reflect issues of awareness rather than absence of provision.

The following recommendations are the complete list gathered and refined through the study. Whilst it became clear during the co-production workshop that some points would fall outside of local authority influence to enact, they remain helpful reflections of what mattered to people, and we retain them here so they might have some utility for future thinking. Recommendations or challenges captured in our focus groups are placed in the **left-hand column**, with the related strengthened recommendation offered in the adjacent **right-hand column**.

<b>Community Support: Co-ordination and use of resources</b>	
Community Engagement Teams were effective at supporting community schemes and helping people get the information they needed.	<i>We need greater integration of community engagement in local areas, e.g., Parish Councils, to benefit more people.</i>
Participants did not always know that local authorities supported communities in different ways during the pandemic.	<i>We need to build ongoing engagement initiatives and connections to help people understand what local authorities do.</i>
People found it difficult to find information about what support groups were available to help them.	<i>Create a hub on the local authority website, a searchable resource where all community groups, as well as third sector/charities can be found.</i>
Communities successfully helped themselves and council-led cooperation mirrored an asset-based model that worked in many ways.	<i>Use the post-pandemic period to systematise and further develop this experience, e.g., by reaching out to community leaders who did not engage with schemes.</i>
The people who received care and support really valued it, but there were others who the council and the community didn’t reach.	<i>How can we connect more people who need support with the services, networks, or support groups they need?</i>  <i>Telecare worked for the elderly and people with health conditions – can we work together to expand this to other people who may need it in a crisis?</i>

**Guidance, Advice, and Information in the Pandemic**

Participants found widespread misinformation in their communities because many did not trust institutions of government. But public health campaigns that collaborated with communities worked.	<i>We need more information clinics that collaborate with communities, such as mosques, churches, temples, or gurdwaras, where professionals from the community are included in the engagement process.</i>
Participants felt their circumstances were not addressed in guidance.	<i>We need to recognise the circumstances and cultural diversity of communities in public health guidance, e.g., a campaign to support people caring for the elderly in multi-generational families.</i>
The language and terminology used in guidance was vague or complex – it was not easy for participants with English as a second language to understand.	<i>Health guidance from public health or local authorities needs to be built on work with communities to identify language that they can understand and relate to.</i>
Participants thought that people didn't always know how to help each other, and there were people whose neighbours did not reach out to.	<i>Co-produce guidance with communities and citizens groups to help neighbours understand needs and support each other – e.g., people from different cultural backgrounds, different family circumstances, or whose needs might be hidden.</i>
Participants with employers benefited from employer support, but employers often did not know how to interpret guidance or apply to funding schemes.	<i>Can local authorities build on the work they did with employers in their communities during the pandemic and widen or strengthen this relationship? This will help employers if they are asked to take on such an important role in a future emergency.</i>  <i>Use the existing workplace health programme to strengthen links with employers to deliver key health messages.</i>
Participants felt stigmatised by media coverage of ethnic minority communities and did not feel guidance properly unpacked the role of social health inequalities in transmission.	<i>Local authorities are powerful communicators and supporters of their communities – Could local campaigns help combat stigmatisation by reflecting the diverse communities they represent and counter negative stereotypes?</i>



### **Supporting Younger Generations and Education**

Participants who needed educational resources or equipment sometimes felt excluded by schemes designed to provide them.	<i>As well as inclusive support schemes, we need engagement campaigns that reassure people that their needs are valid and included.</i>
Participants felt that children had been disadvantaged by the pandemic and needed help catching up.	<i>Can schools and local authorities work with the wider community to help them support children's learning and development and to integrate this into social infrastructure – e.g., by creating catch up tuition sessions in local spaces?</i>
Participants felt that communities had worked so well together during the pandemic – can this work longer term to help support families?	<i>Use initiatives to develop social infrastructure to build on and take advantage of the community cooperation generated by the pandemic.</i>

### **Health Services and Support**

Front-line workers felt that their mental health needs were complex and urgently needed support.	<p><i>We need to integrate mental health support, whether from professionals or self-support groups, into front-line workplaces, like the hospice model.</i></p> <p><i>Ensure that staff have easy access to workplace wellbeing interventions, including mental health support.</i></p>
Front-line health workers felt they couldn't carry out their caring role in the pandemic because of strict application of guidance	<i>Support front-line workers as far as possible (within the guidance) to use their professional judgement and autonomy to help care for the sick and take a humane approach to families.</i>
Communities who suffered from the disproportionate impacts of COVID-19 have ongoing mental health needs.?	<p><i>There are limited resources, but huge need. The health system and local authorities can help signpost people to the resources that are available.</i></p> <p><i>Is there a community cooperation role for mental health support?</i></p> <p><i>Identify where there are communities are experiencing the disproportionate mental health outcomes and develop pathways from community into a range of interventions to meet those needs.</i></p>

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Communities who felt they were at greater risk find it difficult to access resources.

*Encourage greater flexibility in accessing health resources.*

*Ensure more people from disproportionately affected communities are encouraged and supported to self-refer to the services that are available.*

*Work with communities to make health spaces safe spaces for those who still feel at risk*

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# 5. Conclusions

“We can’t pass it all back to the council, all back to the government. We are our brother’s keeper, and we need to look out for each other.” – Female, 66–75, Black-African British.

## 5.1 Belief in community action and cooperation

The participants who engaged with our research from communities that had been disproportionately impacted by COVID-19 shared different experiences; their views on what solutions mattered were not homogenous. However, a common theme, which ran across the focus groups, was a belief that change was necessary and possible. Many had a renewed faith in the ability of communities to respond to collective challenges together. Many of the participants, even if they did not have the complete picture of what local authorities had done during the pandemic, were more trusting that local (rather than national) government could better address the challenges facing their communities.

“There has to be a rethink, a reset, of how countries provide for the fundamental necessities of life. What we’ve been doing for the last 20 years isn’t working.” – Female, 26–35, British-Pakistani.

## 5.2 What does this research mean for the future?

The question of how these findings can be actioned by local authorities is not within the scope of this research. But we believe that the research material has many potential uses and applications in the conduct of local authority work, above and beyond strict ‘implementation’ of recommendations, which will be difficult considering the limited resources available to local authorities at the time of writing.

Clearly, the experience of the COVID-19 pandemic has contributed to a cultural climate where the importance of cooperation with fellow residents and local authorities is more widely recognised by communities in Bedford Borough and Central Bedfordshire. We found, too, that the peer researcher network established for this project became very important for the peer researchers, their communities, and local authority and public health team members who engaged with this project who saw its value in deepening relationships. Rather than outlining firm conclusions, we have made suggestions of how the findings of this community engagement project might be developed in the future.

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### **How to develop the findings from this research:**

- Acknowledging the findings from this research, look to develop robust Local Authority strategic approaches to community engagement, identifying a range of clear outcomes.
- Develop the peer research network to bring community knowledge into different arenas of local authority work and strengthen the relationship between local policy making and social knowledge.
- Discuss and debate the testimony from communities or the recommendations made by these participants within local authority and NHS work teams to identify the small solutions that might help address bigger structural issues.
- Publicise and regularly update communities on how this research has been used in different ways and what influence it has had in local policy making, working practices, or community engagement.



