

A Right to Care

The Social Foundations of Recovery from Covid-19

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Abstract

This report presents key findings from a 6-month ethnographic study on the impact of the Covid-19 pandemic on disadvantaged households and communities across the UK, conducted by anthropologists from the London School of Economics, and associates. This research involved in-depth interviews and multiple surveys with people across communities in the UK, with particular focus on a number of case studies of intersecting disadvantage. Crucially, **our research has found that Government policy can improve adherence to restrictions and reduce the negative impacts of the pandemic on disadvantaged groups by placing central importance on the role of communities, social networks and households in economy and social life.** This would be the most effective way to increase public trust and adherence to Covid-19 measures, because it would recognise the suffering that communities have experienced and would build policy on the basis of what is most important to people - the thriving of their families and communities.

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Inside the kitchen of the Suleymaniye Mosque, Haggerston Mutual Aid head chef Harry Wilson puts the finishing touches on meals as they are packaged and put into gifted Deliveroo bags ready for delivery, 11th May, 2020. For one month the Haggerston Mutual Aid group teamed up with Suleymaniye mosque to deliver thousands of meals to families in need across the borough.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund

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Executive Summary

This report presents key findings from a 6-month ethnographic study on the impact of the Covid-19 pandemic on disadvantaged households and communities across the UK, conducted by anthropologists from the London School of Economics, and associates. This research involved in-depth interviews and multiple surveys with people across communities in the UK, with particular focus on a number of case studies of intersecting disadvantage. Crucially, **our research has found that Government policy can improve adherence to restrictions and reduce the negative impacts of the pandemic on disadvantaged groups by placing central importance on the role of communities, social networks and households in economy and social life.** This would be the most effective way to increase public trust and adherence to Covid-19 measures, because it would recognise the suffering that communities have experienced and would build policy on the basis of what is most important to people - the thriving of their families and communities.

1 | Households:

Tackle the kinwork and care deficit that social distancing measures generate

Although largely invisible in Covid-19 policy, households and their informal networks of carework and support are at the core of a thriving UK society and economy. As a result of Covid-19 policies cutting off usual social support networks and formal social care there has been an emergence of a kinwork and care deficit. The mental health, physical health and financial impacts of these cut networks are significant. Households, and in particular women within them, have had to fill this deficit by absorbing greater care burdens. As a result, particular categories of people with multiple caring responsibilities, or managing multiple households, are experiencing immense pressure.

*We suggest Government policies that restrict social networks of support as little as possible and only as a last measure. When restrictions on households are introduced they should follow **social bubble household policies** rather than arbitrary regulations such as the rule of six that do not match household practices and discriminate against particular social groups. In addition there should be immediate, emergency mental health and care support measures put in place in regions under Tier 2 & 3 restrictions. These would include financing the expansion of mental health care and subsidising, or in the most deprived regions providing free of charge Covid-19 safer child and elder care facilities. These could be on the model of mutual aid networks helping in people's homes or otherwise through the subsidised use of existing private facilities. Alongside this, households should be paid a care supplement similar to a child-allowance through the second wave to recompense them for the burdens unpaid care-workers are bearing. These measures are as important for our economy and society as sustaining businesses through the pandemic.*

In the longer term, community renewal centres should be created. These should be broader in reach than the older Surestart Centres. These would provide formal free or highly subsidised child, elder

and other care alongside mental health and access to small business grants.

2 | Communities:

Build the social infrastructure of communities so they can be adherent and recover

Forms of third sector, mutual aid and Government social care can either help or hinder the social foundations of life in the UK. As we enter into the second wave of Covid-19 we need to address how to strengthen organisations at the local level. This means improving the access, assessment capacity and adequacy of services to meet the diverse needs of those in their communities. We believe that communities themselves should have a role in identifying priorities and co-producing solutions.

*We suggest investment in social infrastructures at community level, so local authorities, citizen groups and the third sector are able to provide complementary and comprehensive support to the diverse needs of their communities. This can be achieved through **the local renewal centres** where paid community champions and peer supporters, local authorities, other stakeholders and public health bodies work together to **co-produce locally appropriate solutions**. Mutual aid networks can be financed through a national mutuality fund and/or national investment bank.*

3 | Economy:

Build an economic package that meets the diverse working conditions of the population

The Treasury's one-size-fits-all policy response was premised on selective aspects of the economy. Firstly, it eclipses the complexity of current labour arrangements at the level of the region, household and community, and their gendered, classed and racialised forms, including the prominence of casual work and in-work poverty. Secondly, they focus on waged work and businesses alone, while ignoring financial and rentier economies and their impact.

In the short term the Government should, as a priority, take a centralised approach to regional regeneration through Government investment, particularly in family businesses and SMEs. This should be carried out in partnership with local authority economic officers. It should track and ameliorate the impact of the pandemic on informalised workers who have been disproportionately impacted by it.

4 | Recovery:

Apply a social calculus to measuring the health of economy and society.

Relying only on economic growth and productivity as a measure of renewal as we emerge from this crisis will occlude forms of ethnic, racial and class inequality. Emphasis on productivity will lead to a dead end of automation and/or rhetoric of zombie companies which should be 'allowed to die', potentially devastating again post-industrial economies. Emphasis on growth will lead to an emphasis on consumption-led growth modelled on supporting middle class households only through hard times.

*We suggest a **social calculus** be applied to the measurement of recovery that includes attention to regional, community and household inequality and how it is deepened or reduced by Government*

policies

5 | Stigma and Blame:

Combat the growth of blame and discriminatory narratives

The uncertainty about, and generated by, Covid-19 has led to the growth of blame and discriminatory narratives across all sections of UK society. People, including politicians, policy makers and the general public, have tried to regain security by drawing on assumptions about social groups. Politicians and the public should be discouraged from circulating these blame narratives. In addition these communications should state that when people become unwell with Covid-19 it's because they are members of hardworking families who care for members of their communities. They are taking the risk of keeping the country and communities going and because of this they may become unwell through **exposing situations**. Alongside this all interventions should be accompanied by Government funding of community information and support through GPs, paid peer-educators, community champions and mental health charities and professionals.

*Policy, communications and strategies of community engagement should disaggregate the BAME category. Vulnerability to Covid-19 should be mapped as a series of structural factors that intersect to create disadvantage in each social situation. More nuanced national and local communications that give clear explanations for transmission in **particular environments** rather than 'within communities' need to be developed. It should be emphasised that these environments are a risk for ALL social groups.*

6 | Data & Evidence:

Generate more accurate data to inform policy on social behaviour

The pandemic has intensified boundaries of stigma and public distrust of the UK Government. This is due to the distance between Government policies and the realities of people's lives, and to political blame narratives. Unfortunately, given the absence of comprehensive population-level data on epidemiological transmission that is independent of testing foci, both decision makers and communities rely on assumptions and, sometimes, stereotypes about how to calculate and explain risk from Covid. This leads to both problematic and sometimes stigmatising policy decisions that don't square with the realities of social life, making it impossible for communities to be adherent.

*We suggest the collection of further **data and evidence, including ethnographic data**, that reveals the impact of the formal and informal care deficit at the community level, particularly in communities under local Tier 2 and 3 social restriction measures. Data must be disaggregated across a range of axes to reduce stigma placed on particular groups such as BAME communities or young people.*



Shukri Adan, founder of the volunteer organisation Connecting All Communities, and her brother Mahad prepare meals in Shukri's kitchen with the help of two friends from the Somali community, 28th June, 2020. Every Sunday they prepare almost 100 meals and deliver them to families on some of the estates in Hackney.

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Introduction: A Social Calculus

The Covid-19 pandemic and Government interventions to deal with it have affected every aspect of family and community life in the UK. Support networks, kinwork and care labour have been, and continue to be, disrupted by social restrictions. In addition, the provision of formal care by NGOs, charities and local authorities has reduced. We have an increasing deficit in informal and formal care that carries a heavy toll for the most disadvantaged in society. While these resources are important to all of us, deprived groups rely more than most on these networks of care to get by. Yet, significantly, it is in the most deprived areas that social restriction measures have continued for longest. Moreover, those who can pay for services such as childcare, elder care, psychological help or domestic work are still able to access these as the formal economy is prioritised over household connections. It is true for all of us that the social foundations of our lives are currently at risk, but the burden of this is carried heaviest by disadvantaged and minority groups. This report reveals these hidden inequalities and suggests how we can build new social foundations for recovery and renewal.

Government policies have so far done nothing to rebuild our social foundations because they have not taken a holistic approach. Public health regulations try to apply a modeller's framing to the realities of social interaction with unintended negative impacts. Epidemiological analyses parse the household as a physical site of transmission rather than an extended network of social support. No concerted effort has been made to engage with local authorities and mutual aid groups to build new long-term infrastructures of social support. Economic interventions have viewed the household as a consumption unit or have only focussed on ameliorating crises in formal waged labour. The financial crisis in paid childcare and severing of unpaid childcare networks have not been fully addressed. We argue instead for new policies based on a social calculus that examine the hidden cost on households and communities of the Covid-19 pandemicⁱ. On the basis of this, we can practice a more realistic version of the public good that takes into account the social foundations of our lives.ⁱⁱ

Such an approach is particularly needed now as households and communities carry a disproportionate burden in absorbing the shocks of Covid-19. It is not surprising that the public is increasingly disillusioned by the gap between Government policies and the realities of their lives. This is often described as 'behavioural fatigue' or 'non-compliance', but our

report shows that this alienation is better understood as a frustration with a lack of attention to the hardships faced by households and communities.ⁱⁱⁱ Our report reveals that what is called public distrust is a socially embedded phenomenon that reflects the limits of current policies as well as the strain of dealing with practical issues of care. Public distrust for current Government regulations arises not from a desire for 'liberty,' or 'non-compliance', but from the sense we all have that we cannot relate Government rules to life. They do not make sense for us because they do not connect to the lived reality of our relations as family, friends, workers and communities. Nor do they prioritise what we most care about, which is the sustaining of relationships. To build the social cooperation necessary to prevent excess illness and death in the second wave, and to forge recovery, we need to bridge this gap between policies and everyday life.

This, we argue in this report, is best achieved through projects of social listening such as our own. Central too is the co-production of interventions with local experts and communities. The regaining of public trust and creation of a shared commitment to overcoming and recovering from Covid-19 is more likely to be achieved if the Government engages with local Governments, regional organisations, communities and households. These efforts must be backed up by greater long-term financial resources provided to regions and local authorities along with Government investment in local public health, mutual aid, formal childcare and community recovery centres. Such engagement and financial support should be prioritised to the regions hardest-hit by Covid-19, which also score highest in the ONS' multiple deprivation index. Without such a shift in policy focus, the foundations of our society cannot be protected or rebuilt, and there will be no economy left.

The significance of building social foundations for recovery and renewal are underlined by the potential for the opposite to emerge from the pandemic—deeper divides underpinned by stereotypes and stigmas. Policy makers and populations are operating with deep uncertainties and insecurities given the lack of scientific knowledge about Covid-19. As anthropologists have long pointed out, such uncertainty produces boundary making narratives and practices as people seek security. In addition, blame is attributed by politicians and the public to explain social suffering. As we saw with the early years of HIV it is only through concerted attempts to push back against such narratives and practices that negative effects can be avoided. Yet there has been little public discussion of the stigma, the growing hate crimes, the policing of social boundaries and the attributions of blame at large in the UK now. Our report includes an open discussion of these divides and suggests alternative strategies to forge social cooperation. These will go beyond communication and narrative 'fixing' to examine the root causes of the credibility of these accounts in unequal social relations.

To be clear, our report is not an argument against policies to prevent the epidemiological

spread of Covid-19. We agree that national restrictions were necessary in March and that current policies do not presently go far enough to prevent a Second Wave. Nor do we think that clinically vulnerable populations can be segmented off from those that are less susceptible to morbidity from Covid-19 as suggested in the Great Barrington Declaration. From our perspective on the community and household, it is clear that such suggestions are at best a fantasy and at worst if applied would segregate and divide us further from each other. We are connected in social support networks across age groups, and it is these networks that keep the rest of the formalised economy going. How would we 'shield' BAME groups who are predominantly key workers; or the grandmother or grandfather who helps a key worker hold down their job by picking up a child from school? Where would a university or further education student go but home to their older family members if they became ill with Covid-19 or the Government shut down their institution? How would we divide the new multigenerational households that have formed to absorb the economic and social shocks of the pandemic into 'rational' age-divided sets?

However, it is clear that policies to prevent the epidemiological spread of the virus minimise social interaction and thereby undermine the care and sharing that sustains social life. This is visible in the recent Tier 1 to 3 restrictions. These place more limits on our social foundations - household and community interaction - than they do on retail, workplaces, universities and the hospitality sector. It is hard to understand why our families, networks of friendship and mutual help, and communities have such a low priority in the Government's hierarchy of protections. We are often told that this is to preserve the economy and livelihoods, but as this report shows such prioritisation creates a heavy burden on all UK households that is not yet ameliorated by policy interventions. This has caused a pandemic of social and mental suffering among elderly people, shielders, young adults, women, minority ethnic and disadvantaged groups widely acknowledged in a range of reports since the first national lockdown.^{iv} Our report grounds these diverse insights on the psychological cost of the pandemic in a holistic understanding of our vital social support networks and unpaid care labour. We show that we can have no economy if these are not sustained and renewed. This is ultimately what we mean by applying a social calculus to policy---to prioritise measures according to whether they reduce inequality within and among households and communities.

Our report is also a call for better and different kinds of data to inform policy. We argue for an approach that, firstly, triangulates existing forms of ONS and public health data with systematic evidence-gathering at community level, across social groups, through ethnographic methods. Second, an approach that acknowledges and supports the informal work of care and kinship that occurs within and between households to sustain life and meet people's needs. Third, an approach that values such informal responses to meeting needs at community level and integrates them with statutory responses to inequality and deprivation during and after the pandemic. Fourth, an approach that remodels economic

policy to account for the range of relations and conditions that contribute to productivity and growth including unpaid, informal and casual work.

To find out the lived patterns of UK society under Covid-19, our group has conducted research across the UK since March for six months. Our report provides a comprehensive picture of how people have received and responded to Government interventions. It deploys anthropological methods – including ethnographic research, quantitative and qualitative surveys – to understand differences in how communities perceive and behave in relation to Government regulations; and triangulates this evidence with data collected by public health bodies, third sector organisations and the Office of National Statistics.

This research has led us to make four arguments with related policy proposals:



Households at the Core

Although largely invisible in Covid-19 policy, households and their informal networks of carework and support are at the core of a thriving UK society and economy. As a result of Covid-19 policies cutting off usual social support networks and formal social care there has been an emergence of a kinwork and care deficit.

Households, and in particular women within them, have had to fill this deficit by absorbing greater care burdens. As a result, particular categories of people with multiple caring responsibilities or managing multiple households are experiencing immense pressure.

In the short term during the second wave we suggest Government policies that restrict social networks of support as little as possible and only as a last measure. When restrictions on households are introduced they should follow social bubble household policies rather than arbitrary regulations such as the current rule of six that do not match household practices and discriminate against particular social groups. In addition there should be immediate, emergency mental health and care support measures put in place in regions under Tier 2 & 3 restrictions. These would include financing the expansion of mental health care and subsidising or in the most deprived regions providing free of charge Covid safer child and elder care facilities. These could be on the model of mutual aid networks helping in people's homes or otherwise through the subsidised use of existing private facilities. Alongside this households should be paid a care supplement similar to a Child Benefit through the second wave to recompense them for the burdens that unpaid care-workers are bearing. These measures are as important for our economy and society as sustaining businesses through the pandemic.

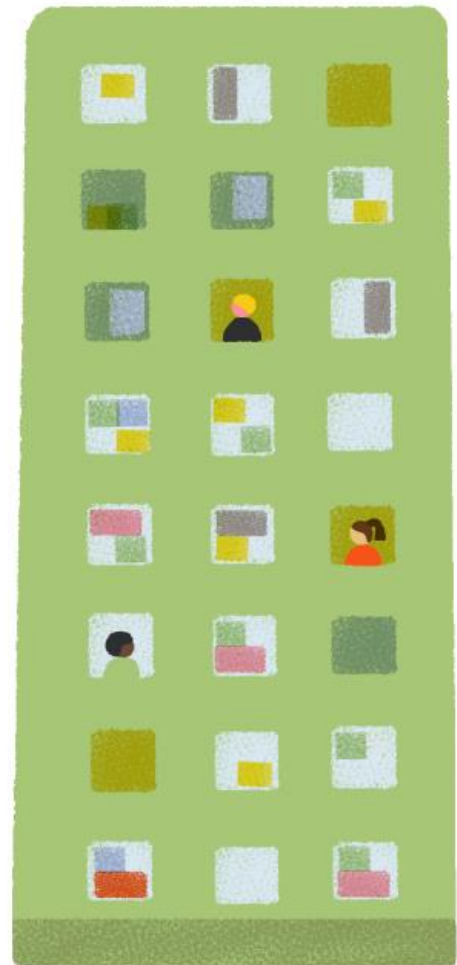
In the longer term, we need to form community renewal centres modelled on the more limited Surestart centres that can help the most disadvantaged areas with childcare, eldercare, mental, public health, mutual aid and economic rebuilding.

Social Foundations

Forms of third sector, mutual aid and Government social care can either help or hinder the social foundations of life in the UK. As we enter into the second wave of Covid-19, we need to address how to strengthen organisations at the local level. This means improving the access, assessment capacity and adequacy of services to meet the diverse needs of those in their communities. We believe that communities themselves should have a role in identifying priorities and co-producing solutions.

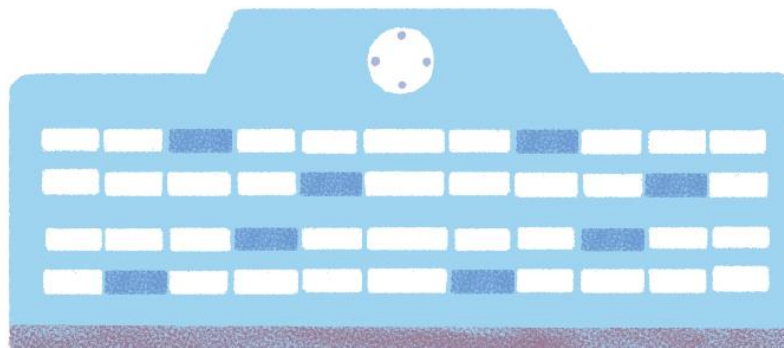
We suggest immediate investment in social infrastructures at community level, so local authorities, citizen groups and the third sector are able to provide complementary and comprehensive support to the diverse needs of their communities. This could be financed through a national mutuality fund and/or national investment bank.

In the longer term, these social infrastructures could be housed and amplified in community renewal centres where community champions, peer supporters, local authorities, other stakeholders and public health bodies work together to co-produce locally appropriate solutions.



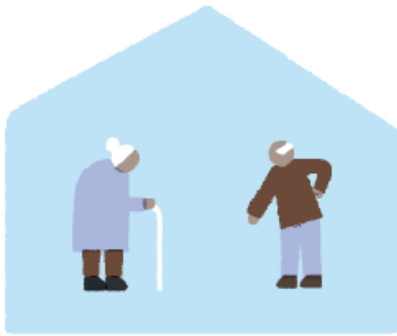
Supporting Livelihoods

Although the Treasury claims to be supporting livelihoods, its policies have created new inequalities. We need to build an economic package that meets the diverse working conditions of the population. The one-size fits all UK wide



model of the economy on which the Treasury's economic policy response was premised on selective aspects of the economy. Firstly, it eclipses the complexity of current labour arrangements at the level of the region, household and community and their gendered, classed and racialised forms, including the prominence of casual work and in-work poverty. Secondly, they focus on waged work and businesses alone, while ignoring financial and rentier economies and their impact. Emphasis on productivity will lead to a dead end of automation and/or rhetoric of zombie companies, which should be 'allowed to die' potentially devastating again post-industrial economies. Emphasis on growth will lead to an emphasis on consumption-led growth modelled on supporting middle class households only through hard times. In the short term the Government should, as a priority, take a centralised approach to regional regeneration through Government investment, particularly in family businesses and Small and Medium Enterprises (SMEs). This should be carried out in partnership with local authority economic officers. It should track and ameliorate the impact of the pandemic on informalised workers who have been disproportionately impacted by it.

In the longer term, we suggest a social calculus be applied to the measurement of recovery that includes attention to regional, community and household inequality and how it is deepened or reduced by Government policies.



Building Cooperation

The UK pandemic has intensified boundaries of stigma and public distrust of Government. This is in part due to the distance between Government policies and the realities of people's lives and to political blame narratives. Unfortunately the absence of comprehensive population-level data on epidemiological transmission that is independent of testing foci, both decision makers and communities

rely on assumptions and, sometimes, stereotypes about to calculate and explain risk from Covid. This leads to both problematic and sometimes stigmatising policy decisions that don't square with the realities of social life, making it impossible for communities to be adherent.

In the short term politicians and the public should be discouraged from circulating blame narratives. Instead to overcome stigma all measures of intervention should be accompanied by communications that emphasise that Covid-19 does not discriminate. In addition, these communications should state that when people become unwell with Covid-19 it's because they are members of hardworking families who care for members of their communities. They are taking the risk of keeping the country and communities going and because of this they may become unwell through exposing situations. Alongside this all interventions should be accompanied by Government funding of community information and support through GPs, peer-educators and community champions and mental health charities and professionals. Policy, communications and strategies of community engagement should disaggregate the BAME category. Vulnerability to Covid-19 should be mapped as a series of structural factors that intersect to create disadvantage in each social situation. More nuanced national and local communications that give clear explanations for transmission in particular environments rather than 'within communities.' There is a need to emphasise that these environments are a risk for ALL social groups. This means attention has to be paid to within ethnic and religious group inequalities as much as to between group inequalities. There is a need also to emphasise that reducing transmission is a responsibility for all socio-economic groups. Any community engagement must actively seek to see the community from different vistas within it before co-producing policy.

In the longer term, active financial and practical support must be given to all community groups, and once they are set up this should be orchestrated through the new community renewal centres.

This report begins by laying out the project and team that conducted this research project, and the methods for data collection and analysis used. It then presents ethnographic and survey data according to the four above arguments. In each of these sections, thematic analysis is complemented by (1) in-depth case studies of particular regions where intensive research was conducted; (2) shorter ‘spotlights’ that illustrate key insights with ethnographic portraits; (3) insights from surveys conducted in parallel with ethnographic data collection. Each section concludes with recommendations for policy-makers and other relevant stakeholders.



Hatzola volunteer Moishe Star, in full PPE, stands outside the Hatzola base in Stamford Hill after cleaning the ambulances at the end of the day, 12th May, 2020.

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Project, Team & Approach

This report is an output of the 'Innovations in Care' project funded by the London School of Economics. It is produced by the Covid and Care Research Group, a collective of anthropologists, primarily from the London School of Economics. We draw on a range of methods such as ethnography, network analysis, citizen science and participatory research. Our research group is collaborative in approach, and works with other disciplines, policy makers, community leaders and community groups across different locations. The group is led by Principle Investigator, Laura Bear and Co-Investigators, Deborah James and Nikita Simpson. It also includes members of LSE Anthropology Department – Fenella Cannell, Nicholas J. Long, Megan Laws and Insa Koch, Teodor Zidaru-Bărbulescu, Jordan Vieira, Anishka Gheewala Lohiya, Jaskiran Kaur Bhogal, Catherine Whittle, Milena Wuerth, & Caroline Bazambanza. Researchers beyond LSE Anthropology have also systematically contributed to the report, including Alice Pearson (Cambridge), Johannes Lenhard (Cambridge), Farhan Samanani (Max Planck Institute), Dora-Olivia Vicol (Work Rights Centre) and Eileen Alexander (LSE Social Policy). All researchers have contributed to data collection, analysis and the co-writing process. Laura Bear and Nikita Simpson compiled the final report, wrote the introduction and conclusion.

This is a report of findings from the first phase of our project. This first phase involved a situational mapping of vulnerable families, tracking their networks of care and how these are changing in response to Government pandemic policies. We also explored how disadvantaged households are now creatively getting by, and to what extent mutual aid practices, support from faith and community groups and provisioning by local resilience forums are reaching them. In addition, we sought to understand how pre-existing forms of stigma and precarity may be intensified through experiences of Covid-19. Alongside this we aimed to reveal what people think about society, public welfare and the state.

Approach

Current statistical, polling, focus-group and activity data tracks broad groups that face problems related to Covid-19 and is driven by top-down questioning. However, on its own this evidence cannot contextualise how multiple factors intersect to produce inequality. Nor can it uncover issues that are relevant to the broader population. Our methodology aimed to break down the existing categorisations of social groups in the UK, and to track the way these forms of disadvantage are generated at the intersection of different identities. By embedding research at the community level we aim to map how and why patterns of deprivation and Covid-19 epidemiology interact. We sought to understand which policies are amplifying or reducing such connections. Please see Appendix 1 for a note on our methodology

Structural Disadvantage

We have identified six key structural factors associated with vulnerability during the Covid-19 pandemic. These include:

- (1) Epidemiological Factors

Rates of infection and morbidity are increased by necessary or voluntary non-conformity to social distancing guidelines. Whether such infection and morbidity results in high rates of mortality depends on the accessibility of services, help-seeking behaviour and existing co-morbidities; as well as genetic factors. In addition fear of illness, or lack of access to hospital care, may also prevent people gaining access to treatment for non-Covid related life-threatening conditions.

(2) Wellbeing

A number of important factors across segments of the population determine wellbeing, including existing mental health conditions such as depression and anxiety that might be intensified under social distancing by loss of therapeutic services or personal loss of friends and family; and substance abuse disorders which might go unmanaged. Further, evidence shows that rates of coercive control and domestic violence have dramatically increased during social restrictions, with services unable to accept referrals and prevent homicides.

(3) Stigma

Stigma might arise from fears around Covid-19, its sources and origins; or may be experienced as avoidance of treatment. Stigma involves current or feared experiences of judgment or negative treatment. Stigma can impact individual behaviour, for instance leading to the avoidance of treatment. Stigma can also colour how different groups are treated, leading to uneven forms of regulation and policing.

(4) Economic Factors

The breakdown of the economy will have both short-term and long-impacts, intensifying existing and producing new forms of precarity. Loss of livelihoods as sections of the economy break down result in lost income, increased household debt and inability to plan over the long term.

(5) Formalised Care

The breakdown of existing welfare systems and policies, both during the pandemic and during the following period of prospective austerity, will have significant impacts. New Treasury policies such as universal credit, wage replacement schemes, furloughs and business loans will mitigate some forms of such precarity, but will also produce unexpected and often invisible new forms of vulnerability.

(6) Informalised Care

The degree to which households maintain dense networks of kinwork, kinship, mutuality, friendship and community connections will affect their vulnerability. Although these networks are also at times a source of exploitation, strain and violence.

Socio-cultural Disadvantage

Structural disadvantages will cross-cut various socio-cultural groups, but how they intersect will be specific to certain communities, genders and age-groups. How disadvantage is conceived of, and experienced, is informed by cultural ideas of gendered personhood across the life-course; meaning its impact may well be different for different communities and generations within them. By personhood we mean the way people imagine and experience their own sense of self – who they are, and what constitutes wellbeing and vulnerability for them – as informed by experiences of the body, household, and wider world. By generation, we mean that the needs, expectations and concerns of people differ across the life course. Therefore, the experience of vulnerability - self-perceived, perceived in others, and in the community at large – is informed by generation and

personhood.

Given this variability we have identified specific kinds of demographics within the UK population that are likely to have experienced the most disadvantage during the Covid-19 epidemic. These categories should not be thought of as discrete closed groups separate from each other. The categories are more like vectors of disadvantage that coalesce in individual and community experiences. In addition, disadvantage emerges from encounters with other socio-economic groups in informal and formal care institutions and workplaces; interactions that have been kept in view throughout our research. We seek to uncover unexpected care networks, formed on the basis of friendships, mutuality, kinship and marriages across 'community' lines and commonalities in the disadvantages faced by post-industrial white working classes, rural and small town communities and those of BAME groups.



Hatzola technician Dovy Sternlicht sits in one of the ambulances at the end of a day, 12th May, 2020. 'Covid-19 didn't read the textbook' he told me. Hatzola is a 24/7 emergency medical response team started by the Jewish community in North London. The Stamford Hill branch has almost 50 volunteers and on a normal day might field 20 calls. At the peak of the crisis it was receiving 80 calls a day.

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I | Households at the Core



Introduction

Although largely invisible in Covid-19 policy, households and their informal networks of carework and support are at the core of a thriving UK society and economy. For disadvantaged groups, this is particularly true as they rely most on the sharing of kinwork among and between households. Kinwork is the physical, financial and emotional work of caring for individuals who are seen to be part of your family and community. To be separated from your kin means you lose connections that are essential to wellbeing and social support. In the UK disadvantaged, post-industrial, disabled and minority groups depend on shared childcare and eldercare to attend employment and pool resources to survive hardship.^v Yet we all rely on social connections to deal with illness, life-events and unexpected shocks whatever our age or background. It is not surprising that restrictions on social interactions and quarantine specifically, have been linked to poorer mental health for all populations overall.^{vi}

These essential networks of social support and care work were severed by the first period of national lockdown from March to June 2020. As measures eased this has left a legacy of inequality and public distrust of Government measures. This is particularly intense in areas in the Midlands and North of England where social restrictions have been never lifted or have been reintroduced. It is highly problematic that one of the first tools of intervention prioritised by the Government has been reducing household interaction to certain numbers of people (the rule of six) or to the smallest social bubbles of two households joining. Crucially, these local restrictions have affected the most socio-economically deprived areas in the UK, deepening existing inequality, without providing any policy ameliorations. Though the policy to support isolating households during local lockdowns and the maintenance of limited social bubbles for childcare are steps forward these are not sufficient. Though the current policies to support isolating households during local lockdowns and the maintenance of limited social bubbles for childcare, with lone households and exceptions made for care for vulnerable relatives are steps forward these are not sufficient. We have an increasing kinwork and social support deficit in these regions.

In order to deal with the second wave the Government is once again seeking to limit social interactions as a first 'easy' measure that survives the political process. Such measures are part of every tier in the Government's new three-tier system. There is no-one to speak for the needs of the

household, apart from the public themselves, so we have listened to them. As we will see, an apparently 'easy' policy tool has highly negative impacts both in terms of the erosion of public trust and disruption of the essential webs of family and community relationships. The burden of maintaining these has been taken on primarily by women as primary care givers who have to navigate the provision of resources and care in the new difficult circumstances. This gendered effect has occurred across communities and classes, but with white post-industrial working class families and BAME groups bearing the greatest weight.

As a counterpoint we suggest that the household is placed at the core of policy considerations and interventions. The Government should be asking, what harm is caused to households by our measures and how can we support them? In their selection of policy measures, those that severely restrict household interaction should be the last tool used with full restrictions deployed only in Tier 3 (high). This is especially because of the current lack of evidence that households and family networks are on their own a significant site of clusters and transmission. A recent SPI-B/EMG paper for MHCLG suggests that the problem of households is broader than simply being one of cutting contacts between them.^{vii} Households are part of networks that include the spheres of work and public interaction. Epidemiological transmission inside and outside of the household is a result of exposure in these other spheres. Therefore, households show the effects of these public interactions such as in pubs or in workplaces rather than being a significant sole source of infection on their own. If there is a higher risk of infection within them, the SPI-B/EMG paper suggests that this is likely to be a product of inequalities in the environmental qualities of housing stock that needs addressing by the central Government. In the shorter term it proposes that risks within them could be ameliorated by public health messaging about safe behaviours around isolation and exposing domestic work in the home. But to ask the British public to severely curtail their household interactions should be a measure that is considered very carefully.

We applaud the Government's addition of exemptions to the 'rule of six' in August, and lone person household bubbling policy. Some of these exemptions currently include large households, interaction for the provision of care to someone who is vulnerable and support groups for mutual aid or group therapy^{viii}. However, we suggest that a more rational social bubble and rule of six policy could be introduced. This would systematically dial up and down the levels of social interaction in terms of numbers of households connecting according to the severity of local outbreaks (as recommended previously by SPI-B).^{ix} We would recommend a graduated movement between different levels of social bubbling in Tier 1 to 3. This would enable regular, repeated connections via social bubbles with larger and smaller numbers of households with different numbers of members. This could include 4 households of any size interacting in a social bubble for lowest levels at Tier 1 (medium), three in Tier 2 (high) and two in Tier 3 (very high). This could be accompanied by a new, more rational rule of six policy. This would prescribe regular connections between the same group of six people spaced out in time, say once every one or two weeks to provide support for those living alone, young people or those without family networks.

The current rule of six in which you can meet people from any six households in diverse interactions without any restrictions on timing draws many more households together for potential transmission. In combination with the current single household bubble policy it also actively discriminates against extended family networks that are so crucial to socio-economically disadvantaged and BAME households. These households have extended kin and care-support ties that can only be met through 3 or 4 households being regularly connected. And they often have more than six people living in a single household making it difficult for the rule of six to work either in public or private. To

apply it means making a choice for only fragments of households to meet each other. More problematically it also makes other members of the public assume that if these households are out in public together they are breaching the rule of six, even though they live in the same house, generating disapproval and stigma. More household-centred considerations and rules would be likely to gain greater credibility and compliance among the UK public.

Our research also leads us to suggest that, as we enter the second wave and recover from it, households should be actively helped. The Government should prioritise greater resources to support immediate local authority provision to maintain childcare, eldercare, mutual help and community connections in new local centres for community provision and revival. These would provide formal care for free or at low cost prioritising first the areas of the UK that have been under social isolation measures for the longest periods of time. They could also be centres for mental health provision, funded mutual aid organisations and the headquarters of paid Covid community champions and peer supporters who could relay accurate public health information. These could have the same social distancing measures as schools and workplaces making them safer places for interaction. The Government is unlikely to attain public trust unless it is seen to care about what the public cares about and needs most—its webs of social connection.^x

Public (Dis)Trust and the Lived Household

Among our interviewees and survey respondents across all groups there was a sense of frustration at the impracticality and inequality of Government regulations around household interaction. Survey responses suggest that the lack of clarity and applicability of Government guidelines to the realities of life in their households led to poor life satisfaction across groups. Many elaborated that they thought the Government's response to the pandemic was misguided 'nonsense'. This message was particularly acute for those who lived alone, those who were carers or required support to care for dependents such as the elderly, children and disabled people, and those who were or lived with essential workers. Those who said they or someone in their household had been leaving the house for work referred often to the stress and 'mental exhaustion' of making decisions to keep themselves and their families safe. Respondents predominantly expressed more worry about the welfare of family members and partners, and about 'bringing the virus home', than about their own personal safety. Frustration with the guidelines was displaced onto relationships leading to conflicts within and between households. Across demographic groups, responses suggest that many disagreements are arising between friends and relatives over contrasting responses to Government messages, media coverage of the pandemic, and news that circulates on social media.

Permeating these responses was a sense that the 'household' bounded by the physical house or flat was not the significant unit for social support or emotional connection. People thought that they had been denied relationships that were essential to their lives and were outraged or saddened by this. ONS categories, epidemiological models and Government rulings bore no relation to their lived realities, especially as support, decision making and care work stretched between households. This sense of arbitrary rules affected even people within the apparently simple categories of single or couple based households. In the context of the pandemic and lockdown, 'living alone' has emerged as a new discursive category of vulnerability in survey responses. The vulnerability of those 'living alone' was more patently evidenced by those over 65, retired and/or disabled, whose freedom of movement had generally been more dramatically restricted in accordance with shielding measures. Many reported suffering from the truncation of vitalising relationships with friends, children,

grandchildren and other close relatives.

Anger about the injustice of lockdown restrictions intensified about this in our survey taken after Cumming's breaches of lockdown rules. For instance, one survey respondent indicated 'the actions of Dominic Cummings and the lack of resulting action by Boris Johnson has been disgusting [sic] and undermined all efforts the public have made'. The majority of respondents thought household rules were unjust and demanded too much sacrifice. This was particularly acute for those whose care networks spanned geographic regions or crossed borders. For instance, one respondent indicated frustration with Government policy as 'people across the borders have been unable to see each other [or] join support bubbles with loved ones in Wales.'

Frustration also increased in relation to the local lockdowns in places such as Leicester (which went into lockdown on 29th June), when the media and politicians appeared to place the blame on increased transmission on multigenerational and, by implication, BAME households. This frustration was particularly acute because households had tried to flexibly adapt to the changing situation. People had adeptly changed their household structures to meet care and kinwork needs in the context of national lockdowns and later local restrictions over the summer and autumn. They experienced a gap between their caring actions filled with emotional meaning and the arbitrary rules of the Government. A way of understanding this gap is to look at how little the ONS household categories (that are the standard basis for policy making in the UK including those for Covid-19) match the realities of households as they adapted to social restrictions.



Spotlight: Flexible Households and National Lockdown

Milena Wuerth

Based on a nationwide survey gauging people's experiences of the coronavirus crisis, we have found that the upheaval brought by the pandemic and ensuing lockdown measures has triggered significant flexibility in households. At times this has been constrained by Government regulations (as in single households). Below we trace this process through the frame of ONS UK household categories. Although as will become clear these categories do not reflect the fluidity, various obligations, strains and frustrations experienced by people in networks of social support. This gap shows that we cannot rely on such statistical measures alone in order to make Government policy on Covid interventions. These need to be supplemented with ethnographic data on the transformations, challenges and frustrations associated with family life under social restrictions.

'One person household': Survey respondents who lived alone were frustrated that the national lockdown froze them into isolation. Often permeating this sense of injustice was the perception that Government definitions of 'household' - bounded by the physical house or flat, according to ONS criteria - did not appreciate the value or necessity of relationships between those living apart; these relationships, especially those in which physical and tactile interaction are central (eg. grandparents playing with grandchildren) have been significantly truncated by social distancing measures. This sense of loss and sacrifice has left a legacy that affects the credibility of measures in the present.

'Two or more unrelated adults': This category includes a wide diversity of households with different sorts of commitments to each other. People found themselves frozen into place with unrelated

individuals in ways that could lead to tensions and dilemmas. Others quickly at the start of the lockdown formed new two person households with siblings who they wanted to support. One elderly respondent, for example, took on a central role in managing her brother's cancer treatment during lockdown, which required constant vigilance to uphold shielding and sanitation guidelines.

'Couple': According to ONS classifications, the 'family' is 'a married, civil partnered or cohabiting couple with or without children. In many cases, respondents who were romantically involved but not married, and those who were married but separated, changed their living situations during or immediately preceding the lockdown period; for example, some frontline workers decided to live separately from their partners in order to minimise their risk of infection, and some shielding people moved out of their homes in order to protect themselves. Living apart in these cases did little to minimise the emotional attachment between partners, often intensifying feelings of obligation to provide for partners' well-being. Once again relationships became flexible, but with an emotional cost of separation.

Lockdown and economic downturn has highlighted intra-familial dependencies, in particular the reliance of adult children on older, more financially stable family members. While this support was not only provided by parents (spouses, grandparents, siblings and other relations also played important roles), the lost earning potential of millennials brought many children in their 20s to move back into their childhood homes. Parents most frequently assumed the bulk of caring responsibilities within the household, often providing social and emotional support as well as financial relief for children in their teens to late 20s. On the other hand our survey also revealed that many adult children had decided to move home for the duration of lockdown if they had parents over the age of 65 to help care for them. Adult children with disabilities generally became increasingly reliant on parents and resident carers during lockdown. For example, several (adult) respondents who identified themselves as autistic reported increased dependence on family, friends and support workers in the absence of regular social contact; many parents of autistic children detailed struggles to adjust at-home care to meet their needs within the constraints of lockdown. These new arrangements led to reports in our survey of great anxiety and tension reflecting new care burdens.

'Lone parent household': According to the ONS, 'lone parent household' indicates any arrangement in which a single parent, regardless of age, lives with one or more 'dependent' or 'independent' children. While single parents with young children have faced intense and deep challenges during the pandemic (especially with childcare and schooling), it is also clear from the survey data that flows of care between a parent and their child/children have been far from unidirectional. Based on responses collected from adults over 18 ('independent children'), 'lone parent households' were often created on the initiative of children who felt the responsibility to care for elderly, clinically vulnerable, or socially isolated parents.

Multi-family households: A significant number of survey respondents who would be classified by the ONS as living in 'multi-family households' had moved in with family members or had family members move in with them during lockdown. This brings attention to the fact that many 'multi-family households' – especially during times of crisis — are ad hoc caring arrangements, deliberately formed to provide for family members' wellbeing and physical health, rather than necessarily permanent configurations. Contrary to widespread assumptions, 'multi-family households' represented in the survey could not be confined to specific class (ie. low-income) or ethnic/cultural (ie. BAME or migrant) background; instead, responses from people of all ethnicities highlighted health- and wellbeing-related reasons for living together and for continuing to do so within the circumstances of the pandemic. This inwardly focussed care often arose from lack of trust in formal

social care providers to follow social distancing guidelines and provide an adequate level of support to elderly and disabled family members; These multigenerational families were formed to cope in a time of anxiety and stress (therefore the 2011 census can't be used as an accurate guide to current UK household structures as these have changed in response to the pandemic). There was a particular association of these new inward looking coping families with very low trust in the national Government and its handling of the pandemic.

Overall, households have responded creatively to the challenges of national and local restrictions, and associated economic challenges. This has involved experiences of frustration, coping, strain and sacrifice. However this has not been recognised in Government policy or communications. Nor is it possible to pick up this widespread social experience through current data collection methods or categories of households. We would propose, therefore, that in policy related to Covid-19 (and beyond) families should not be understood as physical households. Instead they should be mapped and supported through measures that recognise them in their reality as networks of kin, care-work and emotional relationships. Any Government intervention that radically restructures them such as national or local restrictions will be met by coping mechanisms among the public, but also involves a cost in well-being, and related changes in public trust.



A memorial to Oluwamayowa 'Samson' Adeyemi at the Wilton Estate where the Children With Voices community food hub operates, 6th July, 2020. Oluwamayowa was shot dead on the 5th June, 2020 on the Nightingale Estate in Hackney, he was 21 years old.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund



Spotlight: Sikh multigenerational households in the West Midlands

Jaskiran Kaur Bhogal

The definition of what constitutes a household is not one that is consistent among all communities. For the Sikh families interviewed, their household unit extended beyond those that they lived with. It tended to comprise a broader care network. As one respondent explained, although multigenerational families still exist, it is now much more common for nuclear families to live close to one another but in separate houses. In many instances, grandparents, parents, aunts and uncles all form part of the informal care network. It is common for families to pool resources including but not limited to car-pooling, food shopping and food preparation.

During the lockdown, these inter-household networks of care were cut off. In response to these restrictions, the shape of many Sikh households changed. Given this family structure, many of the Government guidelines did not seem to accommodate for this group. For example, when groups of six people were allowed to meet outdoors, it did not consider instances where the household itself was six or more members. This would mean that only fragmented household groups would be able to meet with one another. The later guidance of two households of any size being able to meet is much more accommodating of this type of family because it is based on a more network accurate social bubbling model.

This might be illustrated by the case of one interlocutor, an undergraduate student who lives in a relatively affluent area in Wolverhampton with her parents, twin brother and elderly paternal grandparents. Both of her grandparents are considered at risk and so is her father as he is diabetic. Her parents are both key workers – her mother is a teaching assistant and her father is a locum pharmacist. They have continued to work throughout the pandemic. Once the situation presented itself, the family made the decision to move the elderly grandparents (who are often unwell) to the house of family members' (father's younger brother and wife). This is because they live close by and work from home as lawyers. The family took this decision so as not to put the grandparents at risk as her parents were going out to work. This situation has been very difficult for the original host family. They have not seen the grandparents since the lockdown, and this is taking its toll primarily on the grandparents who rely heavily on the family emotionally. The respondent described this situation as hard because 'it has been a struggle to see them struggle.' She also said that they felt fortunate to have had family close by so that the grandparents could stay with them. She said if this was not the case then she does not know what they would have done. Her father would have potentially had to move out and rent somewhere and her mother may have had to ask not to work or be placed on furlough.

It is important that when guidelines are developed that they consider all types of household and family structure in the UK. Social bubbling guidance between households would be a fairer way of restricting household interactions than a fixed household number such as the current form of 'the rule of six'.

Greater Household Burdens

As a result of Covid-19 policies cutting off usual social support networks and formal social care, there has been an emergence of a kinwork and care deficit. Households, and in particular women within them, have had to fill this deficit by absorbing greater care burdens. As a result, particular categories of people with multiple caring responsibilities or managing multiple households are experiencing immense pressure. For example, evidence shows that the restrictions have produced a ‘squeezed middle’ of middle-aged women; women who are providing both physical and financial care to their children and parents, sometimes while continuing as essential workers themselves. Others are forced to choose one set of caring responsibilities at the expense of others, or to choose unpaid caring responsibilities over paid work or education. For example, one interlocutor, a ‘support for carers’ advocate, indicated numerous examples of people who had given up their homes, jobs and schooling to move in with elderly parents or disabled relatives during the lockdown while paid care services were suspended. They did not consider themselves ‘carers’ and could not access any kind of respite, income or emotional support services. These individuals are increasingly isolated and expressed concern about their mental health and financial situation.

This care burden has hit single-parent households, most often single mothers, hardest. There have been instances where people have been forced to choose between paid employment and childcare, foregoing income or compromising the needs of their children. Many parents, particularly single parents, report complex calculations of risk in attending to the needs of their children, balancing risk of exposure to Covid-19 with the need to access food banks, health or social care services for themselves or their children. When asked whom they felt they had grown closer to during the crisis, single parents overwhelmingly mentioned their children (or grandchildren), especially in cases of adult children moving home after periods of absence. Almost all who responded reported feeling increasingly distant from non-relatives, including friends, colleagues and partners living outside the home. This reflects an inward involution of care networks with a heavy cost. There have been reported rises in calls and referrals to childcare support services, food banks, and other social services by single-parent families, particularly single mothers and pregnant women who are refugees or asylum seekers. The breakdown of child maintenance payments means some partners aren’t required to pay child support, leaving one parent without an income. The lag in universal credit and other benefit payments has had a significant impact on single parent households.

Case analysis of London-based single mothers from low-income households revealed a strong sense that the emotional, care and financial needs of single parents were being ignored by Government policy that was built for middle class interests. One interlocutor stated ‘Now Boris is saying that nannies are allowed to come into middle-class families’ homes. But what about the working-class mums on our estate and the care that they need?’ She gave an example of a relative who was a single mother. This woman was living on Universal Credit and got a job working in a hotel a month before the lockdown. She was immediately furloughed by her employers, only working a few hours each week – resulting in significant financial hardship and preventing her from accessing the benefits that she was entitled to before she got the job. Meanwhile, she is home-schooling and must occupy her primary aged son and unable to access adequate food resources to meet his needs on the £15 food vouchers provided by the school. On the estate where she lives, she doesn’t have any outside space where she can safely let him play. Before the lockdown, she would have had support from her parents and wider network of friends with childcare. The impact of these multiple pressures on her mental health is significant.

Indeed, overall across all households mental health has been impacted by the anxieties of Covid-19, with mental ill-health exacerbated through the balancing act of home and work. Policies have alienated care givers in the home – women in particular – many of whom rely on social networks for self-care. As one interlocutor cited, carers are 7 times more likely to experience loneliness and isolation according to the Carer's UK survey; this is only exacerbated by the lockdown. While there have been instances where respondents spoke positively of staying at home as allowing them to reconnect with their children, most parents who have been sole carers during lockdown have been less than upbeat about their childcare responsibilities. One respondent indicated that being the sole child carer 'has not allowed me to be the parent I want to be, [and] has driven me to the edge of my patience and emotional reserves.' The loss of previous routines and staying at home has not been easy on children either, who also felt 'imprisoned'. The decline in children's mental health was commonly mentioned by survey respondents in discussions of childcare and schooling. In some cases, parents' perceptions of children's 'declining mental health' compelled families to accept risks they might have otherwise been reluctant to take; for example, a grandmother expressed concern about her young grandson who had been 'becoming temperamental' under lockdown and whose mother had decided to send him back to school despite her own immune-compromised condition.

Children with disabilities have had an especially difficult time. One respondent, mother to a 4-year old-boy with cerebral palsy, explained that her child 'has regressed in a number of ways including temper tantrums'. Experiences of loneliness are very common, not just among the limited instances of working and non-working co-habitants who moved house and lived apart during lockdown, but also among the more numerous cases where people are left behind with caring responsibilities at home while their partners or children go off to work. Some respondents reported feeling frustrated, envious of co-habitants who can leave the house to work, while they themselves are 'stuck' with childcare and working from home. Yet others experienced guilt over the fact that co-habitants have to go out to work, or guilty over their own experience of loneliness in comparison to the risks their co-habitants expose themselves to outside the home.

The lack of formal and informal support beyond the household exacerbated this sense of loneliness. For instance, new mothers often join 'Mum groups' prior to giving birth to create communities of care and forums of advice relating to their children. These groups often act as informal counselling networks where people share their concerns about their children and discuss how to raise them. Without meeting, or even forming these groups, new mothers can often feel isolated, as family and other friends can be at different stages of the life course. Our survey found that the incidence of mental health problems after childbirth was high, although very rarely referred to as 'post-natal/-partum depression.' Often this was connected to isolation from close relatives (often the mother's parents) who could have provided both practical and emotional support for the new mother. The absence of partners (most often fathers) who continued to work outside the home — and the associated isolation and fear of their 'bringing the virus home' — was also mentioned in several cases as a contributor to deteriorating maternal mental health. The elderly who live alone, relying on community centres or voluntary activity groups (book clubs, knitting campaigns), can no longer go to meetups and struggle with new forms of virtual social meetings. While some areas report mutual aid groups supporting those most isolated, these are unevenly distributed through the country. Forms of inequality in care have been increased by this patchwork of mutual aid reliant on spontaneous efforts by local groups or local authorities. It is clear that a more central financial support and stimulation of mutual aid is necessary as we enter the second wave and beyond for recovery. This is a point further elaborated on in the next section.

We also found, unexpectedly, that single men experiencing financial stress have been particularly isolated from sources of emotional, financial and physical care, whether this is because they are experiencing restricted access to support networks, or because they are ashamed of asking for help. According to mental health charity Taraki which focuses mainly on Panjabi Sikh men's experiences of mental health, the pandemic had led to many more men and in particular young men reaching out. Often this was for their own mental health but also to get advice on how to support their elders to cope with the lockdown and feelings of isolation. According to the ONS, younger workers, 24 and under, or older workers and those in more routine or less skilled jobs are the most affected by unemployment.^{xi} There has also been an increase in the number of single men accessing services such as food banks.

Key-worker families, especially those of health workers, also reported that their own mental health was unduly strained by the exhaustion of doing their jobs under such uncertain, precarious conditions and with patients often failing to comply with safety/social distancing guidelines. In some cases, respondents' anxiety sprung from the feeling of potential culpability — a fear of infecting others or even of dying and being unable to care for dependent children, partners or relatives. Those related to or living with health workers expressed concern for their loved ones' current and future mental health; for example, a mother worried that when her daughter, an NHS nurse, 'gets a chance to process all of this that it will affect her mental health gravely'. Partners of health workers were also clearly affected by their high-risk occupations.

In addition to loneliness and anxiety across all groups, we found that parents and children who lived in separate households often also provided new forms of physical care to one another, commonly in the form of grocery and medication delivery. In these cases, children of elderly parents were most likely to assume additional responsibility for physical care, impacting personal reconsiderations of typical parent-child relationships. For example, a 59-year-old retired woman had been living with her 83-year-old father before lockdown and became his sole (physical and social/emotional) carer when social distancing guidelines restricted visits from other family members and community support workers. Where networks cannot meet face-to-face any longer it has also led to a new burden of providing physically distanced care. Virtual meetings add to the daily or weekly routines of work, but more importantly many people became engaged in navigating online food or medicine orders for elderly relatives. Overall, national social restrictions and their aftermath have generated a greater burden on households. Accordingly, many respondents concluded that mental health and care concerns should be considered a valid criterion for prioritisation in re-opening and the easing of restrictions.

Formal Care Deficit

While informal care has had to intensify in smaller social networks, access to formal care has decreased. This has added a formal care deficit to already burdened households.

Formal care refers to primarily free or subsidised facilities provided by councils or NGOs and engaged with at local level by the household. These may include, but are not limited to, day care centres used by disabled and elderly household members, midwife services, family planning clinics, women's refuges, nurseries and schools. Usually, these kinds of organisations would absorb part of the household's care burden or offer care and shelter in the absence of this within the household itself. Many formal care facilities utilised by the household are closed to face-to-face visits, no longer accessible or have been lost touch with, due to lack of communication to

convey they are still running. Though some services have reopened, their ability to conduct outreach or run drop-in centres are severely constrained.

Particularly noticeable is the reduction in services for new and expecting mothers, there has been a dramatic decrease in pre- and post-natal check-ups, including the removal of regular appointments to check the baby's health and weight. Some appointments, including check-ups for women in their third trimester (usually weekly) have been moved online although there are certain measurements and checks that cannot be taken remotely. Moreover, women without access to devices or smartphones are left at a serious disadvantage here and mother and baby's health will suffer as a result. In-person services at hospitals, including newborn hearing screening, face considerable backlogs and some new parents are falling through the cracks.

Homeschooling in the first period of national social restrictions has been a significant burden on households, especially low-income or disadvantaged households. For this reason we welcome the Government's current emphasis on keeping schools open even in the highest Tier 3 (High). However there needs to be more preparation for the next potential phase of the second wave when schools most likely in the most deprived areas of the UK will be forced to close due to large-scale community outbreaks. The development of home schooling materials and digital inclusion as a priority would support this. Homeschooling resources could be developed perhaps with existing providers. Particular attention needs to be paid to supporting parents with poor literacy or IT skills, or parents who are learning English. As one mutual aid worker from a Black African community commented 'many referrals are coming through schools, and parents are calling up very distressed.' Parents living in temporary housing or other overcrowded spaces, particularly women who have left abusive households, are finding it especially difficult to support their children in education. Digital inclusion requires long term investment in infrastructure, but even the provision of laptops for the most disadvantaged families would make a difference. Whilst the Government encouraged Local Authorities to apply for laptops for pupils who need them, many families in need did not receive these. Concerted central effort needs to be made to prepare emergency teaching resources for use through the Winter.

Some ethnic minority community leaders expressed fear that the most vulnerable in their communities – particularly recent migrants, single mothers and victims of abuse or mental ill health – were isolated in their homes and unable to access formal care. For example, a psychotherapist from the Somali community expressed anxiety about single mothers – 'Single mothers are also at risk, having been raped, widowed or left their husbands, or their husbands being elsewhere. These single mums are also stigmatised and isolated in their own communities. The mother takes responsibility for her children even if the father is there.' She indicated that one woman had called from a homeless hostel where she is living with her four children trying to home school them, without any income. There are no services that she can reach, and she is worried about who will look after her children if she gets the virus and dies. 'These women don't want to access services because they don't trust the state or charities, they don't see anyone like them who speaks their language or understands their condition.'

Elderly households have experienced the hard edge of a formal care deficit most intensely. They have considerable difficulty accessing care services and everyday necessities including groceries. Some local charities, local counsellors and NHS volunteers have been phoning to ensure their elderly users are in good health, although many of these are running on tight resources and good will as temporary services. Moreover, elderly care service users often access these services in person and so have lost some of their visibility as a result. Increased numbers of deaths during the

pandemic of people at home who had not been discovered for some time highlight the vulnerability and invisibility of elderly and disabled households. Finally, while 'support bubble' arrangements have provided assistance and companionship to people who are structurally isolated (living alone), they remain unavailable to people relationally isolated, for instance people who live with and care for a severely disabled relative or spouse, who themselves are in need of support but do not qualify.

Formal care deficits compound the additional burdens of informal care on households, and the public clearly need support through Government policy on both fronts.



Spotlight on: Being a Mother

Anishka Gheewala Lohiya and Caroline Bazambanza

A formal care deficit has affected the experience of pregnancy, birth and early motherhood. In one interview, this affected a couple who had planned a home birth through a centre which closed due to Covid-19. The NHS hospital was unable to provide a midwife, and advised the couple to hire one privately, costing thousands of pounds. The couple hired a doula (non-medically trained midwife). After the birth, and without a medically trained midwife present, the couple perceived hostility from the hospital regarding vaccinations and other newborn baby checks. In fact, many mothers were in confusion about their baby's vaccinations through lockdown. In some interviews with new mothers, the intersection of maternity leave and lockdown instilled feelings of loneliness at home. With partners working outside of the home, and mothers unable to physically meet friends, family or wider support networks, the emotional, educational and household burdens were often exacerbated.

Particularly for new mothers, Post Natal Depression (PND) and other mental health concerns have not been met with support. There was very little support from local council-run family centres, or any other formal institutions after six weeks. At this stage, mothers have been discharged from active Midwife care and Health Visitor checks.

For mothers of young children (0-4), many lacked structure in their day during the lockdown due to the closure of nurseries. Education of children this young is not monitored by any schools or formal institutions. During this time, the BBC Tiny Happy People programme started up with the support of the Duchess of Cambridge, highlighting that this stage of childhood is a gap where parents are left unsupported in children's education and care. Schools for those registered and older than 4 mostly provided curriculums and supported parents who were home-schooling.

While nurseries were closed, it fell mostly to mothers to organise their day around activities for the children, and some worked through the night. While at least three working mothers in the interviews had help from male partners with supervising the children's activities, the organisation of these household duties such as food preparation, cleaning, and shopping among other housework was left to them. Because of redundancies or the threat of them, economic work left many mothers anxious and working through the night on top of household responsibilities. One new mother, whose partner worked outside of the household, has PND and accessed counselling over the phone. With the lack of privacy living in a small home, closure of schools and nurseries, and her role as primary caregiver in the household, she did not have the mental or physical space to take care of her health.

The lack of kin support networks affected many new mothers' ability to care for themselves and virtual support was not as readily available or easy to access. For instance, breastfeeding clinics

online were less accessible than going to the family centre to meet with a clinician or asking a grandmother or friend for advice or help. Local council support was seen as a gap in institutional care capacities.

Overall, these experiences led to deep estrangement from Government policies among young mothers. In particular they noted that paid nannies and cleaners were allowed into homes before families and friends who provide them with vital support. When future social restrictions are introduced the unpaid care of mothering needs to be recognised as essential and supported. This could be either by continuing formal care to them through periods of social restriction as an essential service or by allowing them to continue, as an exception, to meet in small groups. Certainly, we need to think more broadly and systematically about policies to support mothers of young children beyond simply allowing support bubble childcare networks to continue (the current Government approach). If community centres were created with safe socially distanced spaces for mothers to meet and with suitable subsidised childcare this would help.



Spotlight: Funerals during Covid-19

Nikita Simpson, Alice Pearson and Laura Bear

The lack of 'proper' funerals was distressing broadly for two reasons: lack of closure and disruption of grief process; and lack of 'send off' that people 'deserved'. Some livestream funerals (e.g. Facebook), with mixed responses of some finding it distressing and some helpful, especially if they already have mobility issues. There were widespread reports that only 10 people were allowed at funeral, which some said they thought was against official advice, such as 'my great aunts were unable to attend because the funeral place wouldn't allow more than 10 persons to attend, against Government advice that all close relatives including those shielding should be allowed to attend'. People felt this was 'inhumane' and 'uncompassionate'.

People also reported disruptions to funeral rituals that were also distressing^{xii}, such as these two examples: 'My husband died of Covid-19, I could not be with him when he died. This has adversely affected my mental health. Every process afterwards was difficult. No physical contact with family and friends to help with funeral arrangements etc. I felt isolated and alone and still do. The funeral was dreadful (10 people) and the coffin bearers wore masks. This has haunted me since'. Further, another respondent indicated - 'I am bereaved because I feel that Covid was the reason my husband's cancer treatment stopped. When he died, I was only allowed to see him once in the funeral parlour. I was not allowed to choose what he wore. My husband loved his clothes. For me, this was distressing. I was not allowed to choose his coffin and only 10 people could attend his funeral.' Some say they understand the reasons for funeral restrictions, but much anger was expressed about Government, such as mention of dismay at other exemptions being made for those breaking lockdown. One person suggested that 'funerals could have been conducted outside, to allow some collective mourning.' Many mentioned difficulties from inability to comfort one another physically, not to see or 'hug' each other. This was distress at inability to both give and receive support.

Current Government plans to allow funerals with limited numbers of participants even in Tier 3 is to be welcomed. However a legacy of incomplete marking of death will continue. Families have to make very difficult decisions about who is and who is not permitted to attend funerals and are unable to

mourn together as usual. The best way to overcome this would be national days of mourning the Covid-19 dead and different communications around national suffering. Although the figures of Covid dead have been 'normalised' in public briefings and data streams communities experience a dissonant gap from this. It is this gap, along with the lack of proper social closure of death in all funerals, that is contributing to 'distrust' of a Government whose communications policy does not acknowledge the suffering of the British public. This needs to be acknowledged not covered over by messages that people should simply continue to work and consume to keep the economy going or suggestions that Covid-19 is a moderate risk that can be managed. We need public reflection on what the pandemic has cost at the level of families and communities. And how we can come together in cooperation to overcome this.

Conclusion: Supporting the Household

Households have absorbed a huge burden during the Covid-19 pandemic in the UK. They have coped in creative ways with the challenges faced, in particular those of a formal and informal care deficit. This burden has hit low income households, communities and regions hardest. Although, the cost has been born by us all—creating a deep up-swell in empathy and mutual aid between groups. We all know what it feels like to be severed from the vital connections of social support and care. We all too, particularly women, know fully the extra burdens we have taken on just to keep going. Yet no Government policy has yet fully addressed these issues. Instead, households are still seen as primarily a private arena, which may, problematically lead to transmission events. This needs to change if the Government is to overcome the gap between its Covid-19 policies and all of our lives. We recommend the following approaches:



Short Term Policies (including for the Second Wave)

- Government policies that restrict social networks of support as little as possible and only as a last measure. When restrictions on households are introduced they should follow rational and non-discriminatory social bubble policies allowing multiple households to join at the lowest levels and a revised rule of six.
- Closure of Schools as a last resort. Preparation and extra support for parents with home-schooling including investment and roll out of systematic digital provision for all and development of home-schooling materials.
- Payment of a special Covid-19 compensation allowance to unpaid care-givers in recompense for the extra labour they have taken on in the past national restrictions and now under local restrictions.
- Increased public funding for community level services to conduct home visits and telephonic check-in services to isolated and vulnerable populations.
- Public communications that acknowledge the sacrifices families and communities have made and are making.
- Collection of further data and evidence, including ethnographic, that reveals the impact of the formal and informal care deficit at the community level particularly in communities under local

Tier 2 and 3 social restriction measures

Longer Term Policies

- Creation of community recovery and support centres in the hardest hit regions. These would house funded mutual aid groups, childcare, eldercare, youth groups, maternal groups and paid Covid champions/peer supporters. They should be kept open as long as schools are kept open and should provide practical support along with mental health facilities.
- Public campaigns of reflection on how to cooperate to recover and renewal based on local level co-production and participatory mapping in new community centres or through funded mutual aid groups.
- A sea change in the understanding of the household and the gendered labour of care in economic, public health and social policy. It needs to be placed at the core of all policy calculations and we should establish a national care service through which the unpaid and invisible work of care is recompensed by the Government.



Melissa Francis lives with her two children, T'shaya and T'quarn, in Hackney, 18th August, 2020. After years of volunteering for several organisations in Hackney, she started the CIC Bridge The Gap - Families In Need at the beginning of the pandemic. The aim is to help low income families that require support, get access to the help that's available. Melissa's two children have autism, and the difficulty she experienced accessing these services was her inspiration. Her current campaign to help tackle digital poverty in Hackney has seen them distribute laptops and tablets to over 30 families across the borough.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund

II | Social Foundations



Introduction

Forms of third sector, mutual aid and Government social care can either help or hinder the social foundations of life in the UK. As we have seen in the previous section, households and communities have experienced a formal care deficit during the first six months of the pandemic. As we enter into the second wave of Covid-19, we need to address how to strengthen organisations at the local level. We also need to find examples of provision that have actively generated new cooperative connections. When we use the term 'mutual aid', we mean both the groups which have newly emerged to assist in the immediate aftermath of the first wave and national restrictions, and the older, more established groups which fall under the general term 'mutuality' or 'self-help' groups. The common feature is that they are established and organised by members of the communities they seek to help, and that volunteers are very often recipients of help, and vice versa; thus making for more accessible and approachable form of care, and more fine grained assessment of what kinds of care are appropriate. We argue here that, by drawing on these groups and supporting them, we have an opportunity to build stronger social foundations for recovery and renewal.

This recovery and renewal will require concerted investment in social infrastructures, which are as crucial as the physical infrastructures that are usually prioritised in economic revival^{xiii}. These have been severely eroded over the last decade. Local authorities are the key providers of social infrastructure and have faced nearly £16 billion in core funding cuts from the Government^{xiv}. This number represents a funding cut of 40% from central Government funding to local authorities. As a result of increased local council taxes and the stripping back of care provisions, local authorities managed to bring their overall revenue to an average 74% of pre-austerity levels after core funding cuts.^{xv} These sustained funding shortfalls and slashes to services have created significant harms that, we argue, break the social contract,^{xvi} and put local authorities and communities under unnecessary strain to provide necessary care that the pandemic has only intensified. Indeed, councils forecast spending pressures of £4.4 billion and non-tax income pressures of £2.8 billion in 2020–21.^{xvii} Taken together, this equates to a financial hit equal to 13% of pre-crisis expenditure, and adult social care accounts for £1.8 billion of the spending pressures.

On the ground, this hollowing out of services at local level has increased the risk that local authorities

become dependent on voluntary care providers to meet the service gap, without adequately compensating them. We propose that, crucial to surviving the second wave, preventing harm and rebuilding, is a concerted investment in mutual aid groups and other currently undercompensated organisations. This is particularly important because the Covid-19 pandemic and its effects has placed greater strain on these organisations. There is a significant increase in demand for care provision, with one estimate suggesting that charities face a 43% increase in demand for their care services^{xviii}. The situations of these organisations highlight that current funding shortfalls are not only linked to local authorities, but also to the suspension of major grant schemes and the ineligibility of some voluntary sector staff for the furlough scheme. Charities and voluntary organisations face a significant risk of having to close their doors, which would put increased pressure on public services that are already themselves at breaking point.

Further, disparity in local authority funding has only exacerbated inequalities between boroughs, with wealthy boroughs more able to support the ecosystem of service provision than deprived ones. The latter are in many cases the ones that have experienced higher Covid-19 caseloads and excess deaths. Small grants given out by local authorities were important and well-received, but limited, and often insufficiently targeted to meet the needs of communities. Many local charities and social enterprises were unable to access the Coronavirus Small Business Loan Scheme, as their rateable value was above the threshold. Many grassroots services are often funded voluntarily by their communities and unable to access local authority grants, threatening their long-term sustainability. Social workers and other support staff, because of statutory regulations, are not permitted officially to refer people to such services, despite the fact that they often meet the needs of vulnerable service users better than formal services. It will take resources to rebuild the social infrastructures that are as crucial to the UK as the usually prioritised physical and economic ones.

To create a way forward in this section of the report we propose three critical elements that must be considered in rebuilding care provision: *access*, *assessment*, *adequacy*. ‘Access’ refers to the ability of, and processes by which, individuals and groups might seek out support from care providers. We examine how access to care is different for different groups (the general public, minority/migrant groups, victims of domestic violence, etc.) and ways to overcome the current inequality of access to care. Ensuring that care providers are easily approachable, trusted, and provide an adequate response to need, are crucial first steps in creating care access points. Second, ‘assessment’ refers to the ability to diagnose individual and group need. We explore whether need is visible within communities and make proposals for more inclusive gauges of need. Third, ‘adequacy’ addresses the question of whether the available care provisions match the assessed need, given the stripping back of care services and severe funding shortfalls that have marked the last decade of austerity. We argue that we cannot weather the second wave or recover from it without greater investment in our social foundations.

In the sections that follow, we present specific areas of concern, spotlights and a case study that illustrate problems of access, assessment, and adequacy. We draw on all of these to reveal a set of core principles and measures that can guide us. We can learn from many of the innovative local level responses that dealt with the immediate Covid-19 crisis. Thus, by way of conclusion, we discuss three general policy themes for implementing enhanced care provision across the UK. First, we recommend ‘stacked’ or ‘saturated’ care (i.e. a variety of overlapping statutory and ‘soft’ care providers) rather than mere supplementary care. Second, we call for enhanced open communication and co-creation between a range of groups to assess systematically the need for care. Third, we propose that care providers create enhanced forums for information exchange and discussion about

best practices to foster improved access, assessment, and adequacy.

Areas of Concern During Covid-19

Access, assessment and adequacy of formal care have all emerged as issues during the first period of national restrictions, and remain significant as we enter the second wave. Difficulties are generated as low access (sometimes linked to stigma), invisibility and underfunded provision intersect in the various examples below. These are more than just examples however, they show that particular groups and situations require immediate attention and support from social infrastructures.

Stigma around receiving care

Access to care has been limited during Covid-19. This is due to the increasing stigma around receiving care as practices of provision have changed. Regular patterns of activity that usually cushion caring interactions with the state are no longer permitted due to social distancing, and the closure of centres - leaving people fearful, ashamed and stigmatised to be accessing services that render visible their experience of poverty, violence, or deprivation. For example, as a result of social distancing, queues for social welfare and food banks are visible to communities; food banks are no longer able to provide talking therapy or children's play activities along with food parcels, and a visit from a social worker is more carefully observed by neighbours. Welfare stigma is promulgated by the state's 'pull yourself up by the bootstraps' logic that is intended to discourage 'dependency' on the state^{xix} and which pits taxpayers against those perceived to be 'getting a free ride at their expense' by obfuscating 'the fact that many beneficiaries are simultaneously wage-earners'.^{xx xxi} The stigma surrounding accessing services or welfare is acute for men, and particularly migrant men, for whom the role of breadwinner and the value of work is important to self-worth. Hence, the idea of being a recipient of welfare or charity is perceived as degrading and shameful.

Where stigma reduces interaction with immediate care provision, a number of negative consequences emerge. Firstly, the extent of need can be greatly misjudged if those who require support are reluctant to approach care providers. This can lead to a misrecognition of the scale of emergent problems and inadequate allocation of resources. Misjudging need can also lead to acute exacerbation of 'hidden' issues which require more involved and costly intervention in the long-term - e.g. development of serious mental health issues; emergence of chronic health conditions.



Insights from the survey: Accessing Care

The distribution of incomes amongst those who reported accessing Government social services during the pandemic when they had previously accessed 'none of the above' was heavily skewed towards the lower income brackets. Only 31% of those newly accessing social services described themselves as 'employed and working', compared with 41% of the total surveyed population. 23% described themselves as 'furloughed/unable to work due to lockdown,' in comparison with only 13% of the total surveyed population. 10% of those newly accessing social services described themselves as 'looking after family/home as full-time job,' compared with 5% of the total surveyed population.

Amongst those newly accessing social services, the average life satisfaction in April 2020 and in the week before completing the survey was lower than the average within the total surveyed population. On average, respondents in this cohort ranked the risk of lockdown to their household finances as significantly *more severe* than the average within the total surveyed population. They ranked the risk of lockdown to their personal wellbeing as *significantly higher* than the average within the total surveyed population. They ranked their personal experience of the coronavirus crisis relative to that of others in their local area as lower than the average within the total surveyed population; many cited financial struggles, deteriorating mental health, and hardships dealing with children at home during lockdown.

17.71% of respondents newly accessing social services had used 'Food Banks' or 'Food Vouchers' during the pandemic. 42.71% had newly been accessing 'Mental Health Support.' Other newly accessed services included, in order, 'Mutual Aid Groups,' 'Citizens' Advice,' and 'Debt Advice.' Services were generally described as easy to access but insufficient or ineffective due to shortages of supplies and/or staffing. In addition, respondents complained about long wait times for priority supermarket delivery slots and remote therapy appointments. Those accessing mutual aid or getting assistance through their employers generally had only positive feedback to report. Localised and pre-existing social support networks – often related to local authorities, employer-employee relationships, or communal aid/charity groups – seemed to correlate with higher respondent satisfaction and ease of access. The respondents who expressed the most frustration and difficulty were those attempting to access Government-provided social support or advice for the first time and without personal assistance. Difficulty with technology also presented a significant barrier to access for many older or socially isolated respondents.

Migrant Communities/Those with No Recourse to Public Funds

There is significant fear of accessing local services on the part of some groups, particularly in migrant communities. Some do not trust services, or local authorities, to meet their needs, reporting bad experiences with professionals in the past, and hence are unwilling to do what is necessary to access health and social care. Migrants and undocumented people report service environments being hostile and a lack of language-specific communications, leaving them reluctant to access treatment for Covid-19 symptoms on the assumption that they are not entitled to care. People with No Recourse to Public Funds (NRPF) status, refugees who are in the process of being resettled and unsuccessful asylum seekers, report that they are stuck in limbo, vulnerable to homelessness, unable to access social welfare support and fearful that accessing charitable or local authority services will make them visible to the state. People with No Recourse to Public Funds and non-EEA status don't always understand their right to healthcare, preventing them from accessing hospitals if they fall sick with Covid-19. In order to ensure initial access and understanding of care available, some local authorities work with independent bodies dedicated to migrant/refugee welfare to ensure that those who are fearful of contact with the state still have channels to access information and support.

Institutional Care

Institutional care interventions are increasingly distressing. There has been an increase in the number of children taken into care. Children subject to care proceedings and taken into institutional care during this period would normally be able to have regular contact with their parents while their case was being considered, but this has not been allowed during lockdown. This denial of face-to-face visits has been particularly traumatic for parents. A majority of parents in this demographic are

economically disadvantaged and do not have access to digital platforms to interact with their children via technology, where this might otherwise have been arranged. This situation is acute for women who have recently given birth and had their children taken into care proceedings. Infants in these cases are missing out on vital bonding opportunities with parents, to whose care they may still be returned. The overarching concern here is that many decisions in relation to institutional care interventions were 'streamlined' during the initial lockdown period - e.g. adoption/fostering requirements became less stringent during the initial lockdown period due to lack of resources and prohibition of face-to-face contact. Institutional care professionals are concerned that poor decision-making procedures during this time will have significant long-term consequences which will likely require detailed intervention from statutory services.



Insights from the survey: Institutional Care

All respondents who were classified as living in a 'Foster family' were identified as white women between the ages of 53 and 68. Four respondents listed their jobs as 'foster carer'; all others reported other forms of paid employment (legal worker, social carer, gardener). All women expressed dissatisfaction with the Government's lockdown regulations, with several expressing frustration that lockdown had not happened earlier. None reported accessing formal social services before or during the pandemic, and only one respondent reported receiving formal financial benefits ('Housing Benefits' before pandemic, 'Housing Benefits' and 'Universal Credit' during pandemic).

One respondent – a 63-year-old woman with two foster children, aged 16 and four months, listed 'fostering community' as her main source of external support, explaining that 'there are particular stresses in fostering that only those in the same circumstance can appreciate'. Two respondents mentioned 'Local authority' as a primary source of external support, with one reporting that 'the LA have supported me with the boys [her foster children]'. All those who chose to offer further insights in the last section of the survey focused on the Government and the wider public's lack of social accountability during the pandemic. Two specifically expressed concerns about people participating in protests and demonstrations, while most others focused on the Government's inability to provide accurate information and to ensure widespread compliance with social distancing regulations.

One foster carer who contracted Covid-19 early in the pandemic reported that 'having to spend 14 days in isolation with my foster kid (age 19) in our small flat when I had the virus put an intense strain on our relationship'. In contrast, another respondent reported that the lockdown had brought her closer to her foster son (age 18) who moved home from university and is afraid to leave the house.

Food Provision

Food distribution organisations, already experiencing increasing demand prior to Covid-19^{xxii} noticed a steep and sudden rise in numbers of users during the lockdown period. The food distribution element of many of these organisations was, prior to lockdown, paired with 'social' intervention - e.g. running of workshops, informal gathering spaces, language training programmes, signposting to other services etc. These additional services were partly aimed at reducing stigma around the acceptance of food. Building a reciprocal relationship with users is also key to the approach of many of these organisations, whereby recipients of food are also able to volunteer. Lockdown measures and social distancing meant that, for many organisations, their operations were pared-back to focus

solely on the distribution of food parcels.

Access to a range of different types of food distribution organisations was an important factor during the lockdown. Some more established groups provide food on a limited basis - e.g. only allocating one food parcel in an allotted time period, or means testing of users. More informal, or indeed newly formed organisations, were able to fill gaps where those in need were unable to approach larger or more established organisations.

With the expectation that many of these organisations will see high demand into the medium and long term, a number of concerns exist around financial sustainability. Firstly, because of the unexpected and sudden increase in service users as a result of lockdown, previously planned annual budgets were exhausted over the space of a few months. Local authorities face a similar issue in that their own budgets were drawn upon to respond to the most urgent needs, and thus little local authority funding is available for food distribution organisations. Other sources of funding - large grants, private donations, national level funding - has been forthcoming, but much of this is tied to short-term use, and uncertainty around longer-term funding arrangements is troubling. Food distribution programmes are also often part of larger community organisations, and rely on revenue from other arms of their organisation to fund the food distribution schemes which have ceased operation during lockdown - e.g. hiring out of events spaces. The major worry is that, as funding sources are exhausted, these organisations will cease to operate, leaving large numbers of people without access to food.

In expectation of continuing high demand, these organisations are also keen to ensure that those elements which lessened stigma can be rebuilt. Having a greater element of choice in food received, through a voucher scheme where appropriate, is one potential avenue to making this process more dignified, as is breaking down the provider-receiver relationship through more reciprocal engagement.

Mutual Aid Groups

Mutual aid groups were formed as an immediate response to the crisis and are often celebrated as a solution for it. While the scope and dynamics of these groups varied considerably from place to place, a number of themes regarding the role of mutual aid and care became apparent. Firstly, mutual aid groups tended to respond to, and highlight, gaps in care provision. Where people-in-need felt that the response of the state or established organisations was inadequate or prohibitively slow, or where fear of interaction with the state was a factor, the mutual aid groups provided an alternative, informal route to care. Another defining feature of the mutual aid groups is the concentration on hyper-local provision - many groups focused their efforts on a neighbourhood, or on a single street. The role of the mutual aid groups going forward therefore is likely to be as a stop-gap service, or as a sign-posting resource. They cannot fulfil all the required rebuilding of social foundations and infrastructures on their own.

Care at School

Schools have faced difficulties in sustaining their pupils' access to food and have been through a process of trial and error in working out how to keep children fed during lockdown. Some invited families to collect food from school before deciding this contradicted 'stay at home' guidelines and left shielding families underserved. The move to food vouchers was widely welcomed since this empowers families to choose their own food for their children, but using these vouchers for online

orders needs to be clear and simple in order to serve shielding families that are avoiding supermarkets. In many cases, parents have reported that the vouchers are impossible to cash in, they face long wait times on welfare websites, or they have difficulty in securing slots for delivery of groceries from allocated stores.

Some schools have tried to compensate for lack of contact with vulnerable students by making phone calls, home visits, or asking to see the pupil when delivering food, to maintain welfare monitoring. This however is a poor substitute for the contact-time that school attendance provides. Whilst those about whom there were already welfare concerns or known vulnerabilities have been 'checked in on', those developing new social or relational problems in the household during lockdown are likely to have their problems go unnoticed.

Mental Health

There has been a steep rise in referrals coming from GPs into mental health services following the lockdown. These are individuals who were previously not known to the service, and local experts suggest that there might be several mental health related issues that are hard to quantify and hard to address. One key issue is the lowering of thresholds regarding the number of doctors who need to sign off on someone being sectioned. It was previously the case that two doctors needed to sign off on a person being sectioned, but during the lockdown, only one doctor needed to sign off on someone being sectioned. In addition to a possible lack of oversight leading to wrongful sectioning, this is likely to lead to a steep rise in the number of people being sectioned. Local expert concerns include questions of where to physically place the increased number of those who are sectioned and whether there is sufficient capacity to provide required care, given the fact that mental health had already not been receiving required attention.

Domestic Abuse

Whilst increased domestic violence cannot be attributed directly to pandemic circumstances, the latter do exacerbate existing catalysts such as alcoholism and stress at home. Victims are anxious about fleeing because there is nowhere to go, and they are scared of the virus if they leave the house. Situations are escalating more quickly. Local interlocutors have reported an increase of perpetrators smashing victims' phones, so there is no line to the outside. There are Government schemes and services that can be accessed via the phone, but if victims have no phone access, they are not visible to care providers. The breakdown of services is having an adverse impact on women, especially single mothers. There are challenges with getting the right kind of disability support, which keeps vulnerable people in abusive situations. Victims have to see their perpetrators when handing over children where a third party or school used to be involved. Furthermore, the closure of public spaces such as schools, libraries and children's centres, which formerly provided significant referral or mediation of social services and interpersonal support to parents, has hindered the ability of care professionals to assess potential safeguarding concerns. Individuals experiencing domestic abuse have been severely impacted by the closure of community buildings. Many are unable to access the public spaces like schools or libraries, women's groups (or digital technology) that is needed to reach out for help or to be contacted by professionals. Public messaging about what domestic abuse and coercive control is, and routes to support (e.g. 555) needs greater prominence in public media in order to help identify abuse and highlight methods for accessing support.



Insights from the survey: Disability

Three general kinds of responses were identified in the survey in relation to disability: (1) family members and friends worried about the ability of relatives with learning disabilities to understand and comply with lockdown regulations, (2) people with disabilities or close relatives frustrated with declining availability and accessibility of care and support during lockdown, (3) immuno-compromised people or their relatives characterising their vulnerability to infection as a new kind of disability.

Access to social and financial services: Respondents raised concerns about the victimisation of those made dually vulnerable by being both immune-compromised and reliant on Disability (or other financial) Support. For example, one respondent told of the eviction of her housemate's friend who refused her landlord entry because of her fear of contracting the virus in her immune-compromised condition. The process of applying for financial services (such as PIP) were described as exacerbating anxiety and leading to increased dependence on close relatives, trusted medical practitioners, and known support workers in place of Government-provided social support. For example, a 63-year-old woman living alone and undergoing cancer treatment explained that, having heard so much contradictory advice on shielding, she '[chose] to trust the healthcare team, very little faith remains for the Government'.

Learning disabilities: Parents express significant concern for children with learning disabilities, for whom the uncertainty of the pandemic and the disruption of daily routine were especially detrimental. One 63-year-old, 'white'-identifying mother, for example, expressed most concern for her son who 'has autism and has developed Tourette's like symptoms because of his change in routine and fear of Covid-19'. Parents of children with learning disabilities commented on the cessation of respite care and lack of sufficient childcare.

Concern was expressed for deaf and blind people who are less able to access support services online or by telephone, with the suggestion that support workers trained to assist the disabled should be allowed and encouraged to continue providing safe, in-person care. In most reported cases, the burden of care for those with severe disabilities was largely devolved from Government and health authorities to close relatives and friends. For example, one respondent mentioned being the '[primary] carer for [her] disabled husband,' making it 'difficult to tend to [her] own needs in terms of going out and socialising with others'.

When physical distance created a barrier to care, familial carers expressed intense feelings of guilt, frustration, and anxiety. For example, on 56-year-old 'female'- and 'white'-identifying respondent, reported that '[my] sister is on her own in another city, disabled and in great pain. She has had her hip replacement surgery postponed and as I am her only possible carer post-op she can't have it until it is safe for me to have her on my home. She also has poor mental health exacerbated by her physical condition'.

Respondents who identified themselves having a disability often commented on the difficulty of accessing public- or Government-provided services, as well as prioritised food delivery, and generally expressed less discomfort with social distancing regulations. Many said they had already been living in quite socially insulated settings. Uncertainty about the continuity of financial and social

services and the effects of the pandemic on care-related resources and childcare were common worries amongst people with disabilities and their relatives or carers.

In written comments, having a disability (or being 'disabled') – although most often disabilities did not make people more physiologically vulnerable to infection – was used to imply a state of elevated risk during the pandemic and, in some cases, was a reason for shielding. 'Disability' was often the reason respondents stated for worrying about someone they knew, frequently without any additional explanation (eg - response to question 'Who of the people close to you have you been most worried about during the lockdown period, and why?' is 'My grandson - disability'). Those who elaborated further commonly mentioned the additional barriers to understanding that relatives and friends with learning disabilities faced when asked to comply with disruptive and opaque lockdown measures. With limited understanding of what and how social contact must be limited, people (especially young adults) with disabilities generally experienced isolation from friends and external support networks as more extreme, disorienting, and debilitating.

This phenomenon placed additional responsibility and stress on carers and concerned relatives - most often parents with disabled children or adult children with disabled parents. For example, one middle-aged woman writes about her disabled daughter: 'I haven't been able to have her stay with me and she can't understand what's happening. This has caused anxiety for both of us'. Additionally, people expressed concern and anxiety about relatives and friends with disabilities who were living in care homes or reliant on at-home carers because of the additional risk of transmission in social settings.

Social Bubbles: Support for those with care-intensive disabilities was often an impetus to form 'social bubbles,' even before this was discussed as official lockdown policy. As one respondent wrote about her uncle who is 'severely disabled with Polio and elderly, over 70, suspected dementia': 'my parents paired their households immediately before lockdown as there was no choice as my Uncle would have had no assistance at all, he has no carer or support otherwise. He is also not classed as vulnerable on the govt [sic] list but clearly is'.

Autism: Parents of children with autism expressed particular concern about the disruption of stabilising daily routines, considered a 'lifeline' for some, and potential gaps in education and social learning due to school closures. Several parents reported being separated from older children with autism - who had been advised to shield and lived with a partner, friends, or in a care home - during lockdown at great cost to the mental health of all involved. Parents of people with autism and respondents with autism themselves described social isolation as particularly challenging and disorienting, often causing ripples effects of anxiety and tension within the household.

Several parents described unprecedented incidences of self-harm, and respondents with autism disproportionately reported suffering from conditions such as post-traumatic stress disorder, extreme anxiety, and depression. No parents or respondents with autism specifically mentioned receiving social support from local or national Government; instead, most relied more heavily on communal networks, support groups, and mutual aid. For some, the disruption of family support networks has had adverse mental and physical effects.

Digital Provision

Lockdown has underlined the importance of access to digital communications technology, and concerns around 'digital poverty' have been widespread. Groups who already experienced some form of social isolation prior to the pandemic have experienced a 'double isolation' in that lack of

digital resources has led to further exclusion. This has been most acute for elderly people and children from disadvantaged families.

Virtual programs have both strengths and weaknesses. For example, in the provision of care for children, virtual programmes are beneficial for families whose schedules or other difficulties would prevent them from attending classes in person. Nonetheless, virtual classes and groups are generally not a substitute for the social, physical and cognitive stimulation that in-person settings allow, so the former are unlikely to facilitate early-years development in the same way.

Supporting education at home has been more difficult for parents with poor literacy or IT skills, or parents who are learning English. Parents living in temporary housing or other overcrowded spaces, particularly women who have left abusive households, are finding it difficult to support their children in education.

Children in economically disadvantaged households have less access to technology and the internet, and schools were worried that they will not be able to 'close the gap' between advantaged and disadvantaged students caused by lockdown. Some teachers report that the responsibility for this cannot fall to schools alone, but rather it requires higher level action to improve equality of opportunity and outcome. Whilst the Government encouraged Local Authorities to apply for laptops for pupils who need them, many families in need did not receive these.



Insights from the survey: Digital Provision

People most often mentioned digital services in the context of online shopping (mostly food delivery) or communication with friends and family. Many described shopping online for relatives (often elderly parents or house-bound children) as a new form of financial support or physical care they had been providing since the start of lockdown. Respondents often expressed concern for those who were less able to access online services, often mentioning older relatives or acquaintances who they knew were struggling. A few respondents specifically mentioned dyslexia as a barrier to accessing vital financial and social services, and a contributor to heightened feelings of isolation and abandonment. In several cases, respondents attributed their dissatisfaction with lockdown to the difficulty of communicating with friends and family online. Many said that messaging, video calls, and online gatherings (including online church) helped them feel less isolated but did not compensate for the loss of in-person interaction; this was especially true for those who had experience bereavement and were required to conduct or attend funerals virtually.

These areas of concern have highlighted how important investments in social infrastructure and foundations are. The UK public have rallied to help in mutual aid groups, but these on their own cannot solve the numerous problems of access, assessment and adequacy experienced in the situations above. This can only be created through new eco-systems of saturated care working at central, regional and local levels through new forms of cooperation by national and local Government.



Shukri Adan and her friend Fartun Osman prepare the salad for the meals they make every Sunday at Shukri's house that will then be delivered to families and homeless hostels around Hackney, 28th June, 2020.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund



Case Study:

Stacked Care and Social Foundations for Recovery in Hackney

Connor Watt and Jordan Vieira

The borough of Hackney in East London ranks highly on several deprivation indices that underscore the incredible importance of care provision. These indices include high levels of child poverty (41.3% - 3rd highest in London), high poverty and isolation among older people^{xxiii}, and a high proportion of out-of-work benefit claimants (10%, highest in London^{xxiv}). Gentrification and austerity have simultaneously impacted local community dynamics, as they have across East London more broadly. The city is facing a severe housing crisis that is 'rooted in an urban project to recommodify and financialise land in a global city'.^{xxv} Both individual and institutional actors seek to capitalise on new and profitable opportunities made possible by privatisation. Such privatisation has significantly reduced local social housing stocks and has increased the rent rates for private housing through the removal of rent controls in a city where wage growth has not matched this rate increase^{xxvi} amid a decade of austerity measures. Indeed, while employment in Hackney is relatively high, so too is the level of in-work poverty due to inadequate wages^{xxvii}, yet another index of deprivation.

Gentrification has contributed to social fragmentation over recent years; several groups that we spoke to conveyed their experience of 'two Hackneys'. On the one hand is an older, more established, poorer, and mostly BAME population (notably Caribbean, Vietnamese, Orthodox Jewish, Turkish/Kurdish). On the other is an incoming and affluent (mainly white middle class) demographic that can afford the increasingly privatised housing market. This division mirrors social fault lines throughout East London, notably also in the Canary Wharf financial hub/Isle of Dogs region. The pattern of gentrification in Hackney, particularly in the south and west of the Borough, has the potential to exacerbate community tensions and lead to greater division. In areas where gentrification is prevalent, the sustained underfunding of councils can also lead to increased community tensions. This is often the case when the local authority feels it must attract affluent incomers by building luxury housing and prioritising other developments that they feel will attract wealthier residents at the expense of ensuring effective services for current residents. These tensions were somewhat increased over the course of the lockdown, as BAME communities were more vulnerable to the epidemiological effects of Covid-19, more likely to be key workers, and also felt that their actions and movements were more strictly policed than those of white residents. Despite this context of deprivation, tension, and fragmentation, we highlight how particular (and perhaps unique) features of the borough and its response to the pandemic illustrate good practices of care provision that other communities and Local Authorities might replicate.

During the Covid-19 lockdown in Hackney, class and ethnic divides somewhat softened to allow for cross-community forms of care. This has been a welcome (if perhaps temporary) development, not least due to the strain placed on statutory care providers and the fact that Hackney was especially hard-hit by high Covid-19 mortality rates at the onset of the pandemic (ranked 4th of all regions in England from March to June 2020).^{xxviii} We suggest that a contributing factor of this cross-community care serves to illustrate, in part, what we can learn from Hackney and its community-driven response to the pandemic: the borough is home to a dense network of voluntary and community groups, many of which are a legacy of the austerity years and dedicated to food provision. In response to the lockdown, immediate needs (especially for food) were met by this dense network of formal and

informal foodbanks, community organisations, and mutual aid groups. The rapid response to Covid-19 and the lockdown was to ensure that all residents had adequate access to food, and the bulk of this effort was directed by these voluntary groups.

Additionally, mutual aid groups were formed in every ward shortly before the Government announced the lockdown. Most of these mutual aid groups concentrated on 'hyper-local' areas within their wards (i.e. a small neighbourhood or even a single street). The bulk of requests directed to the mutual aid groups were for grocery shopping or prescription collection for vulnerable or shielding residents, or those who were otherwise unable to leave their house. Mutual aid groups were approached as an alternative to statutory or established voluntary groups chiefly because of their rapid response (requests were usually completed within a few hours) and/or the informality of their approach (many users noted a reluctance to engage with council/formal services either because of surveillance concerns or anticipating an ineffective/inadequate response). Hackney Council also developed their own voluntary service. This service was similar to the mutual aid groups in that it focused on building a volunteer base that could carry out shopping or befriending services for Hackney residents who are unable to leave their homes, but it took a few weeks to come into effect.

A key element of Hackney Council's response to the pandemic is the Community Impact Report. This document had been part of a poverty alleviation project prior to Covid-19. It is updated weekly, drawing on the knowledge of all council bodies (e.g. education boards, social work teams, disability support networks, and youth workers). The report examines in fine detail the issues faced by different communities throughout Hackney, and it proposes interventions that might alleviate these issues. Regular updates to the document are of key importance in order to assess and adequately meet any emerging and changing needs. The inclusion of voices from all council services ensures a comprehensive assessment of need throughout the borough and discussion about how to improve access and adequacy.

The Council have also established a care networking group called 'Neighbourhoods' alongside the Community Impact Report. This is a regular discussion group organized by the Hackney Council for Voluntary Services (HCVS), an independent voluntary-sector umbrella group. The 'Neighbourhoods' meetings were originally aimed at improving health outcomes for Hackney residents. Again, as Covid-19 emerged, the meetings were reoriented to deal with challenges emerging from the pandemic and lockdown. Each neighbourhood meeting focuses on a small geographical area in the borough and brings together a range of care providers within that area (carers associations, food banks, GP surgeries, mutual aid groups, voluntary groups, housing associations, social enterprises). They are able to liaise about emerging and exacerbated vulnerabilities, and they can signpost to each other where appropriate. This enables more comprehensive assessment of need within a small area and ensures that multiple routes to accessing support are available.

As part of the Council's general response to vulnerability, they build care access routes explicitly to support groups of people who are reluctant to approach the state for help. These coordinated networks that bring together statutory and independent community-based care providers enable those who are unable or reluctant to approach the state for help to be referred to independent organisations. For example, those without recourse to public funds who need food or housing support can be referred to the Hackney Migrant Centre, an independent voluntary group that supports migrant communities in the borough. This referral service and sustained communication among care providers in all sectors and levels of formality highlights the vital importance of intentionally providing support that is 'softer' than, or alternative to, regular statutory support from the state. Such care is a positive, practical, and beneficial resource that serves to 'stack' or 'saturate'

care provision within communities so that care needs might be met. Again, comprehensive assessment of need that considers people who might be isolated and less visible to networks of support (and which is achieved in part through such mechanisms as Hackney's 'Neighbourhoods' group and Community Impact Report) is crucial to adequate care provision. Many organisations in the borough voiced the desire to build an even more inclusive support network through which those unable or unwilling to reach out for support can also receive support. In collaboration with voluntary organisations, the council are beginning to develop a system of local 'champions' who will act both as sources of information about types of need in their hyperlocal area, but will also be able to feedback other information, such as changes to Covid-19 regulations.

This picture might appear to some like a relatively strong community and third sector response that adequately supplements state care provisions and resources. However, we cannot stress enough that the state's care provisions must be expanded, and that further austerity would lead to widespread collapse of support systems that now cater to large groups of people. Despite the strong voluntary response to the lockdown, there are a number of serious concerns about care provision in the near future. Many voluntary groups, especially those involved in food distribution, are facing financial strain as they are inundated with increased demand due to the inability of the state to meet its own demand. Prior to Covid-19, one 'community hub' based in the north of the borough had used its large premises to run a number of regular community events: a foodbank, twice-weekly 'community meals', parenting advice sessions, a nursery, etc. Apart from some paid staff, the organisation relied on a base of volunteers. The organisation also rented out its premises to 18 local groups on a regular basis, and this formed a significant part of their income. After Covid-19 struck, the organisation redirected all efforts to focus on provision of food parcels and cooked food. They experienced a trebling of food bank users during this time. Many of their already-existent volunteers were vulnerable to Covid-19 and hence unable to work, meaning that new volunteers had to be found. A large portion of these new volunteers came from local mutual aid groups. Those groups that had regularly rented rooms were now unable to do so because of lockdown restrictions. The loss of income and volunteers, compounded by the steep rise in demand, meant that the organisation used much of its annual budget in the immediate response to Covid-19. Hackney Council were unable to replace this funding shortfall, as their own budget had been severely impacted by the pandemic response, and extra funding for local authorities was not forthcoming from central Government. The organisation was able to apply for some funding from national funding bodies, but this was restricted to short-term use. Predicting a sustained increase in demand for food support, the organisation worries about how they will deliver their aid with uncertain funding arrangements going forward.

There are also issues that operate beyond the reach of the local authority or voluntary organisations. Many groups in Hackney felt that the immediate response to Covid-19 and the lockdown, which focused on food provision, was relatively successful. However, they expressed concerns that, as the moratorium on rental evictions ends and the furlough scheme begins to recede, they will not have sufficient capacity to deal with the emerging housing and jobs crisis. Again, we emphasise that the current financialisation and privatisation of the housing market must be reassessed so that vital social housing stocks are grown rather than depleted. The next section in this report addresses further the questions of job loss and economic impact.

Generally, Hackney has been effective in assessing need and ensuring access to support systems on a small scale due to the existence of already-active grassroots/voluntary/community organisations and an active council which interacts with a politically engaged population. Covid-19

served to highlight gaps in this system, gaps which the council were then able to respond to with a mix of adapted statutory care and signposting to community services - a 'stacked' network of care provision, where multiple bodies are able to meet a need in different ways. Regular communication between these actors has ensured a greater comprehension of changing and newly emerging issues, but the capacity to actually provide care is reliant upon increased levels of funding for local authorities and organisations. Increased funding is crucial in that the council and organisations have vastly increased numbers of vulnerable users and depleted budgets in the wake of their initial response to Covid-19. Hackney therefore reveals, to some extent, the forms of stacked care and social foundations that are necessary for survival of, and recovery from, the pandemic in the UK. But this has to be supported by new central funding for such ecosystem; and co-creation of solutions with communities amplified by national level policies.



Spotlight on: Homelessness in Cambridge^{xxix}

Johannes Lenhard

Homeless people, known to be among the most marginalised groups least connected to care, were hit hard particularly during the lockdown beginning in late March in the UK. First, several groups in danger of rough sleeping were pushed onto the street during the early phase of Covid-19. These include people being released out of prison (~30% of people in emergency hotels in Cambridge) and 'hidden homeless' people (e.g. couch surfers being pushed out from their unstable housing because they were unable to pay rent or because the hosts wanted to protect their families). The number of people sleeping rough hence further increased, a problem that was fortunately recognised and worked against by central and local Governments with emergency funding. Across the country, they provided accommodation (at least partially due to concerns around public health (homeless people becoming 'super spreaders') as well as support (through local homeless support institutions).

Secondly, however, support was less easy to access, particularly in its specialised form e.g. for mental health and addiction, two problems affecting a majority of people sleeping rough. People in standard (homeless) accommodation as well as in emergency hostels were, for instance, not able to access drug tests easily and regularly while the risk of overdosing was increased. Often this was further fuelled by script distribution (e.g. for methadone, a heroin substitute) being less frequent, leaving recipients with higher quantities of the substance at once. Drug support groups were either completely cancelled or switched to online, a format that many homeless people either are not able to engage with (not having regular access to internet, e.g. in the emergency hotel) or found less helpful. Similarly, mental health support services, which were already hard to access before Covid-19, were suspended for long periods both in their outreach and in-patient form. Many people, while accommodated and fed, were left under increasing stress and pressure – further channelling mental health struggles and substance use – but without the necessary specialised support. A less fragmented support system, where for instance dual diagnosis support (for people struggling with mental health and addiction) is available 'in-house' within homeless (accommodation) organisations, would provide a stronger safety net for the most vulnerable homeless people. Such a strong localised safety net would be able to strengthen responses to unforeseen events, such as an extended lockdown, in the future.



Dr Paul O'Reilly does a consultation with a patient over the phone, 3rd April, 2020. Once the consultation is complete he writes the necessary prescription and the patient is then ready to be housed in one of the Government funded hotels, a scheme aimed to get the homeless off the streets and self-isolating.

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Spotlight on: Early Years Providers in Oxford^{xxx}

Farhan Samanani

Early-years care often involves a challenging mix of intimacy and uncertainty. Prevalent challenges, such as those surrounding (breast)feeding, sleep or mental health, can take a heavy toll or even come to feel all-encompassing for parents, as such challenges may upset everyday routines, relationships, and wellbeing, while also triggering a cascade of further issues. In Oxford, many early-year providers have recognised and adapted to such challenges by developing an open-ended model that recognises, for example, that the line between issues of breastfeeding, and those of mental health, adequate sleep, isolation or economic insecurity, may not be a clear one. This blurring of lines can also mean that parents themselves may struggle to identify and discuss the issues they face, as such challenges may not fit into discrete categories. As a result, many early-years organisations and practitioners within Oxford have come to adopt an open-ended approach to early-years care that prioritises: face-to-face contact; an extended or ongoing period of familiarisation and assessment that enables the identification of complex problems; and an interconnected approach to support which either provides multi-faceted care or else attempts to connect clients with other care providers to help create a robust network. All these facets of quality early-years care, however, face significant challenges firstly through the ongoing impacts of austerity-related cuts – which materialised in the Oxfordshire early-years sector from 2015-2016 onwards – and now from the impacts of Covid-19 and related policy.

Covid-19 has created particular challenges in establishing the bonds of trust, familiarity or understanding required for adequate assessment. This challenge is compounded for minority and marginal communities (e.g. communities lacking significant English-language skills, teenage/young mothers, those at risk of CSE) where many organisations relied on paid outreach workers to visit people at home, or in specific, now-inaccessible, venues such as places of worship or community centres. These challenges in assessment are partly linked to the dynamics of virtualised services, and partly to corollary issues such as access to and competency with technology. Virtualised services either do not easily allow for open-ended engagement (e.g. something comparable to visiting a drop in play or music session) or else do not easily allow for parents and carers to raise more personal or intimate issues, the way they might do so by pulling someone aside, in person. Similar factors make ensuring accessibility a problem, and service providers report that they have seen changes in the demographics of clientele from in-person to virtual services, and are not always sure how to re-connect with those they are not reaching. Finally, service providers are raising concerns with a situation where access to care is contingent on the ability of parents and carers to self-diagnose issues – and so come forward seeking help – not only because this can be a tricky process, but because relying on this can sometimes lead to framing issues more narrowly, and thus pose a challenge to ensuring continuity or adequacy of care.

Conclusion: Investment at Point of Need

Austerity had severely impacted individuals, communities, and institutions over the decade preceding Covid-19, and the pandemic has worsened the already dire capacities for care provision. A key component of all systems of care is the making visible of need. As spaces of contact reopen and allow care professionals to assess unvoiced and unexpressed concerns, this must be bolstered by care systems where a range of ‘stacked’ overlapping statutory and community care providers can assess and respond to need. Barriers to access of care, such as stigma or mistrust of the state, will lead to the need for greater overall intervention. Being able to intervene in a preventative manner, for example at the onset of mental health issues, domestic abuse, or in an early-years child setting, can be less burdensome than intervention in light of long-term harm. Statutory care providers must also consider how they provide support to those who may be reluctant to approach the state.

Ensuring a variety of scales of care can reduce ‘blind-spots’ in assessment procedures and ensure equality of access. Inclusion of a wide range of modes of care (e.g. statutory bodies, schools, established voluntary organisations, informal care providers) in a local network can ensure that the risk of missing certain at-risk groups are minimised. Embedding care networks in hyper-local systems of knowledge – through, for example, new Covid-19 recovery community centres proposed in the previous household section, housing association networks, and in collaboration with community workers – can help in forming a more comprehensive understanding of need, and can also aid in connecting with those who are isolated from systems of care.

The long-term effects of the collapse of local service provision and data collection are not understood: for instance, the lack of support for new mothers in breastfeeding could have long-term impacts on child health; the lack of referrals to some domestic violence services could risk their funding sources. The marked increase in reliance on statutory or community care networks since the Covid-19 lockdown means that a collapse in these already overstretched services would place large numbers of people at acute risk and leave swathes of the population without access to the most basic of services. This underlines the need for increased funding and support for local authorities and community organisations.

There is a need to invest in services as we come out of the lockdown at the point of need. Research and guidance need to be channelled to supporting these services and keeping them afloat. This is not only for crisis services (such as those for domestic violence), but for all public services like libraries, nurseries, and schools which provide a gateway for referral and act as important spaces for public interaction. This will alleviate pressure on crisis services like the police and ensure that intervention occurs before the onset of more acute problems. This needs to be a long-term shift.

Care should be thought of not only as intervention in response to a specific issues, as including the more fundamental efforts of many of these groups to draw people out of situations of isolation and introduce them to arenas of social interaction. Investment in new community recovery centres would enable this holistic approach to recreating social foundations.

Our research has found that overcoming the care deficit means investing in community recovery, particularly in areas hard hit by Covid-19, and experiencing existing forms of deprivation.



Short term measures (including for the second wave)

- Sustain community care provision by:
 - prioritising further financial support to local authorities targeted to the most deprived and worst hit areas
- Understand the changing needs of communities by:
 - proactively addressing local manifestations of isolation and building assessment procedures which aim for comprehensiveness
 - scaling assessment – ensuring Local Authorities have the resources necessary to carry out continual assessments of care in different parts of their communities
 - embedding co-creation of social care policies and participatory mapping in new community recovery centres
- Increase the cohesion and reach of the community response by:
 - facilitating local care providers to create enhanced forums for information exchanges between them and discussions about best practices in order to foster improved access, assessment, and adequacy.
 - building in non-statutory avenues of care for those reluctant to approach the state such as those with NRPF status.

Longer term measures:

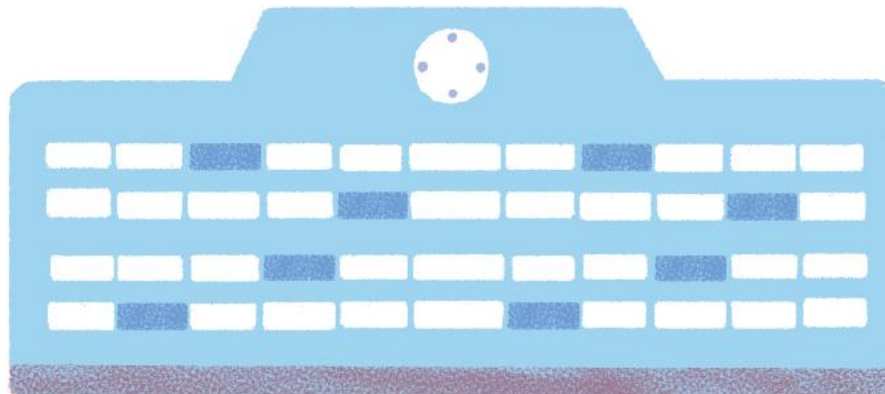
- House mutual aid networks in the new Covid-19 community renewal centres
- Set up a national mutuality fund that can release regular flows of income to mutual aid groups, so the network of mutual aid is evenly distributed across the state. This would be a kind of national investment bank that is focused on social infrastructures which are as important as physical infrastructures.
- Apply a joined up approach to all infrastructure, physical and social, that looked at its social benefit or applies a social calculus to its evaluation.



Volunteers Ziggy Noonan, Carletta Gorden, and Michelle Dornelly from Hackney charity Children With Voices sing along to Whitney Houston as they pack bags with food at the community food hub on the Wilton Estate Community Centre, 6th April, 2020.

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III | Supporting Livelihoods



Introduction

The UK's economic responses to the Covid-19 pandemic have been hailed as the 'end of austerity policy' that has prevailed since the 2008 financial crisis. Indeed, where the Prime Minister Boris Johnson was introducing an 'efficiency review' to justify 'every penny' spent in only January, by June he was promising not to cut spending, and comparing his project to that of President Franklin D. Roosevelt's 'New Deal' program of the 1930s. Yet, as one interlocutor interviewed pointed out, the difference between New Deal USA and Johnson's UK is that the former was underpinned by 'the greatest transfer of wealth from the rich to the (white) working class in world history'. Indeed, the post-war nostalgia that has been evoked in the Treasury's project and propelled by the news media has compellingly presented a message that 'we're all in it together'. However, one interlocutor mused, echoing a familiar refrain circulating on social media: 'they say we're all in the same boat, but I think we're in different boats weathering the same storm'.

Indeed, through our ethnographic research a different picture of economic life in the UK has emerged: one which would suggest that the Government's project is designed for a particular kind of waged worker, and based on a limited vision of what, or whom, the economy is for. Our perspective comes from tracking not 'the economy' from afar, but livelihoods—or the ways in which households and communities get by through a range of paid, unpaid, formal and informal work. Crucially this means that we can take into central consideration issues such as debt, precarity, small scale family enterprises and rents that are seen as only being on the sidelines of the economy as 'anomalies' and are not at the core of Government considerations. As a counterpoint to current policies, we argue for policies that support livelihoods, or the ability of families and communities to sustain themselves through hard times. We do not assume that supporting the profits of the largest businesses, financial institutions or rentiers achieves this end. The situation of the disadvantaged and precarious must also be taken into account in a total understanding of livelihoods, especially in the regions hardest hit by Covid-19 and social restrictions.

On March 20th 2020, the UK Chancellor, Rishi Sunak, announced a suite of measures to support businesses and their employees through the coronavirus crisis. Designed to support 'the economy' through the lockdown period, these measures included centrally the Coronavirus Job Retention Scheme, or 'furlough' scheme, which allowed all UK employers with employees on a PAYE scheme to designate some or all of their employees as 'furloughed workers'. The Government provided funds for these employers to keep paying the wages of workers, and to keep them on their payroll, while

they were not working or were working at reduced hours. The scheme allowed employers to claim up to 80% of their employees' salary, capped at £2500 per month. It was extended after the end of June, and will close at the end of October. Other policy measures introduced for individuals included: the increase to the Universal Credit standard allowance on 6 April 2020; the Self-Employed Income Support Scheme which involved grants for self-employed individuals worth 70% of average monthly trading profits, capped at £6,570, and the potential to defer Self-Assessment payment. The Government has also introduced a suite of other policy measures for businesses, including the deferral of VAT payments, business rates relief, the Coronavirus Small Business Grant, the Retail, Hospitality and Leisure Grant, the Local Authority Discretionary Grant, Bounce Back Loan, Small and Large Business Interruption Loan Scheme, Corporate Financing Facility, the Eat Out to Help Out Scheme and the Local Restrictions Support Grant. According to Treasury figures, spending approved for measures to support public services, businesses and individuals amid the coronavirus has risen to nearly £190bn.^{xxxii}

Sunak has expanded the furlough scheme further in the Winter Economy Plan, launched in September. The new Job Support Scheme will see the Government pay a third of hours not worked up to a cap, with the employer contributing a third and the employee contributing a third – in lost wages. The employer contribution was decreased to 5%, expanded business grants and self-employed grants on October 22nd – at the time of writing. The scheme is designed to ensure that employees will earn a minimum of 77% of their normal wages, and will last for 6 months. It is complemented by the Job Retention Bonus, where employers will be able to claim a bonus of £1000 in February 2021 for every employee who is kept on over the three month period. Further, the Treasury has stipulated that they will pay two thirds of the wages of employees working at firms that are told to close their doors in the event of a lockdown.

Our research showed that the model of the economy on which these policies were premised misconstrues current economic relations. Firstly, it eclipses the complexity of current labour arrangements, including the prominence of casual work and in-work poverty. Secondly, they focus on the role of labour in contemporary economic arrangements, eclipsing the significance of asset inflation and rentier extraction as drains on businesses and households. This also obscures how forms of ownership and investment are generating different economic and social vulnerabilities. In this context, one-size-fits-all policies have distributive consequences that may exacerbate existing inequalities.

The Government's policies have been focused primarily on replacing the wages of the UK populace, so as to maintain their consumer power and contribute to a productive economy by supporting businesses. This is underpinned by an imagination of the ideal-typical UK waged or salaried securely-employed worker, whose wages are sufficient to support them to be both productive citizens through consumption and paying taxes, and to support social reproduction for themselves and their families. For this ideal typical worker, disruption to consumption patterns could be temporarily prevented through the replacement of wages, leading to the stabilisation of businesses from whom they consume. However, on August 12th, the Government announced the worst decline in GDP in the past quarter amongst all G7 nations. Early estimates for July by the ONS suggest that the number of payroll employees fell by 2.5% (730 000) compared with March 2020. The Universal Credit Claimant Count reached 2.7 million in July 2020, an increase of 116.8% since March 2020. The youngest workers, oldest workers and those in manual or elementary occupations were those most likely to be temporarily away from paid work during the pandemic. The ONS also report around 300,000 people away from work because of the pandemic and receiving no pay in June 2020. The

three months to June 2020 saw strong falls in pay; total nominal pay fell by 1.2% on the year and regular nominal pay fell by 0.2% (the first negative pay growth in regular nominal earnings since records began in 2001).

Furthermore, the wage-centric measures which left applications for furlough at the discretion of employers disadvantaged the ~1 million people in the UK who work on zero-hours contracts in the gig economy.^{xxxii} It is important to remember that employment statuses in the UK distinguish between employees, who enjoy the highest level of protections, and workers who lack some of these rights, including the right to redundancy pay. As bearers of an employment status characterised by flexibility, agency workers engaged in the on-demand gig economy were already a disposable labour force. The Job Retention Scheme's focus on employers entrenched that vulnerability.

Our research indicates that the Treasury project was not in touch with the realities of casual work, gig-work, depressed wages, in-work poverty and deprivation that are part of the status quo in the UK. The result of this dissonance is a range of inequalities, between those who can access Government support and those who cannot, that exacerbate existing long-term forms of economic exclusion and regional deprivation. Our data reveals the ways in which economic policy has played out in people's livelihoods. Its implementation in practice, in an economy that is already marked by an inequality between those fully and casually employed, led to a series of bifurcations between those considered productive workers and consumers, who could access furlough through their employers; and those who could not access furlough due to casual or precarious employment arrangements, thus considered unproductive and entitled only to Universal Credit, or excluded altogether from public funds. Our research has shown how these bifurcations are lived and experienced both materially as income loss and poverty, and emotionally as shame, guilt, distress and insecurity. However, our question is not only who is left out of the Treasury's picture of productivity, but what the Treasury's project obscures about the contemporary economy. The following sections will illustrate these bifurcations and their ensuing inequalities. Throughout we will propose other approaches that would support livelihoods more equitably.

Beyond the Model Worker

Essential Workers

Essential workers have experienced stigma both during the lockdown if they continued to work, and as lockdown has eased. The Government-mandated risk assessments in workplaces that are to be completed by individuals require employers and employees to assess their own appetite for risk. There are startling accounts of NHS workers and other key workers in the newly homeless population, as fears of transmission result in their exclusion from homes and other shelters. Some parents were unsure as to whether they qualify as a critical worker and thus whether they were entitled to childcare during lockdown. This was especially true early on, when education and day-care settings were closing and before the full list of critical workers was released. This led to speculation and anxious uncertainty, with many parents unsure as to whether they would be able to access childcare and therefore continue to work. There is a perception among essential workers that they are triply disadvantaged: unable to access Treasury schemes, having to make complex calculations of risk in order to continue working, and stigmatised in their communities due to their potential exposure to Covid-19.

Furlough

The current furlough scheme is perceived by some as creating a two-tier welfare system, where those who are relatively well-off in already stable jobs are given generous support through furlough, while those already in poverty and/or in precarious employment are reliant on Universal Credit. This is layered on a further bifurcation between well-off white collar workers who can work from home, and manual workers who cannot and thus have to access furlough – a split that prefigures the automation divide. The furlough scheme was actuated by the employer as opposed to the employee, and accentuates the existing inequality of power between employer and employee. The fact that furlough was a possibility, not a right, has left many workers with a sense of uncertainty and powerlessness, which has placed an immense pressure on mental health and family relations.

The fact that the Self-Employed Income Support Scheme is linked to past tax returns, in turn, left recently self-employed individuals in limbo. There are a significant number of cases where people who had less than 2 years on the job were dismissed suddenly. The lack of clarity and Government supervision on how furlough was to be administered also left the scheme open to abuse. There was a growing concern amongst advisers that employers were taking advantage of the scheme by telling the HMRC that their staff were on furlough, while asking them in fact to continue working. Such abuses are, of course, unlawful. But without a clear mechanism for how to check one's status, there was virtually no way for workers to know whether they had been furloughed; and equally, no way to report an employer who had asked for Government support but refused to pass it on. Further, there are cases where employers introduced the notion of furlough to their staff as: 'continue to do the same job, but take a 20% pay cut'; or 'continue to do the same job part-time'.

The fact that the scheme operated on an all-or-nothing basis until July 2020 put workers and employers who experienced a reduction, but not complete halt, in business activity in the uncomfortable position of resorting to informal arrangements. Those who are employed in precarious jobs, particularly those who are casually employed, on zero-hours contracts, or employed through an agency or in the gig economy, have found it difficult to access income support. Many of those in such precarious positions have been laid off or have no available work. If they have been able to access income, it often does not cover their basic needs. Those on informal or casual contracts are usually those who are vulnerable in other ways, and so this has intensified other problems. Some of these people were relying on in-kind support and patronage from their usual customers, for example a painter had rent waived for decorating the property of his landlord, or a hairdresser who was receiving some payments-as-donations from clients who would normally have gone to her during this time; or cleaners who were dependent on the kindness of employers to see them through hard times.



Insights from the survey: Furlough

Survey data showed that, in assessing their experience relative to that of others in their local area, many respondents extolled the stability provided by the furlough scheme, which many acknowledged as a privilege not afforded to 'others' (e.g. essential workers, unemployed). Several who ranked their experience especially highly mentioned that they were receiving full pay under the furlough scheme and therefore were able to maintain a standard of living similar to (or higher than) before the

pandemic. No respondents complained about the amount of income they were receiving as part of the furlough scheme. Several mentioned the convenience of receiving furlough payments while being able to look after or spend additional time with family at home.

Universal Credit

Though the standard allowance provided by the Universal Credit (UC) scheme has been increased^{xxxiii}, there are significant challenges for people getting onto the scheme or navigating the welfare system for the first time. Existing problems with UC provision have been exacerbated during this period. For instance, interviews with caseworkers at the Work Rights Centre revealed that there are a number of cases where migrants who sublet informally in properties where they covered rent in cash, were penalised in their UC applications for their inability to evidence the costs of their accommodation. Whereas the cap for furlough was £2,500 a month, when claiming UC, a single person over 25 who could not prove their rent costs received a little over £400 a month. Further, complaints have been made about the devastating impact of UC on mental health service provision prior to the pandemic that has only been exacerbated in the present moment.

Morally, UC was also mired in mistrust and stigma, particularly for first time users and migrant workers. In a world where migrants are valued, and learn to value themselves, for their ability to 'make an economic contribution', being driven to the welfare system can feel like a demoralising descent into denizenship. The inability to navigate social services has highlighted for some groups the ways in which the system was not designed to meet their needs. For people who built a whole sense of self upon economic activity, an ability to work hard and 'pull oneself up by the bootstraps', the blanket call to 'sit and wait' for the fiscal authority to call or for payments to come through was demoralising. Through the course of the lockdown, employment advisers found themselves spending a lot more time mentoring people who historically had hardly had a day off work. This can be particularly damaging for men socialised in a culture where masculinity is tethered to an ability to provide - for the immediate and extended family. Where Universal Credit or wages weren't sufficient people turned to social services at local authority level such as food banks, as explored in the previous section on the Care Deficit.



Insights from the survey: Universal Credit

Survey data showed that those who applied for UC after the outbreak of the pandemic generally found the process relatively accessible but slow; many complained about the length of wait time before financial support arrived (often five weeks) and about unexpectedly low payments. Those who had already been receiving Universal Credit before the pandemic generally had fewer complaints. Those who had applied for Unemployment Benefits or Universal Credit since the beginning of the pandemic were less optimistic about their personal experiences of the Covid-19 crisis relative to that of others in their local area, with several noting that they had been made redundant and did not have access to furlough or 'paid leave' as they knew others did.



Sami Ayad is a volunteer with the Children With Voices community food hub, 6th April, 2020. Born in Sudan but raised in Brazil, he came to the UK for his PhD, and had just moved into an apartment overlooking the food hub on the Wilton Estate. He saw what was happening below, and came down to lend a hand.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund



Case Study: Work Rights Centre

Dora-Olivia Vicol

The first day of the lockdown when I was working from home I got a lot of calls. Old clients, new clients, everyone was calling at that time, who had lost their job – in cleaning, construction, restaurants, wherever, everywhere! It was a very depressing day; it was awful. And I kept saying you can apply for Universal Credit... but - I knew that whole sectors were just down [...]. And they can't just go back and find another job, say, in the construction sector. They have to change the whole sector they've been used to for ten or fifteen years [...] We started looking at their CVs, at a cover letter, and say: 'maybe you can work for the supermarket'. But sometimes they don't want to hear it, they want to think it's temporary...It's a shock.

(Lora Tabakova, Service Provision and Development Manager, the Work Rights Centre)

The Work Rights Centre is a charity dedicated to employment justice. Every week since 2016, a small, multilingual team of advisers have been working with people who experience employment rights breaches, such as non-payment and unfair dismissal, or who are simply looking to improve their social mobility by finding new employment, or accessing welfare in times of worklessness. Most of the men and women who come by the advisers' desks are Eastern European migrants or Britons from Black and Minority Ethnic groups. They work in manual occupations, as one of the staff described it in the vignette, in the type of jobs that keep London fed, cleaned, and rising. What they also shared however, was a position in the precarious tier of the labour market; where work is short term, transient, and far from the sense of security which the Chancellor set out to instill in his address. The few months since lockdown was instituted have been the busiest in the charity's short history. The sense of alarm described by the adviser captures the realisation that, under the lockdown, demand for the charity's help almost doubled. Two teams of service providers in London and Manchester working a total of four days a week, would see between 50 and 60 new clients per month before the pandemic. In the three months lockdown, that figure went to 90.

The lockdown has raised a series of new issues.

- The fact that furlough was a possibility left at the discretion of the employer, not a right, has left many workers with a sense of uncertainty and powerlessness. Advisers recounted working with clients who had lost their jobs, only to see other colleagues furloughed or retained as active staff. In some cases, employers abused the concept of furlough by continuing to ask their staff to deliver their shifts - only for 80% of the pay.
- The fact that the Self-Employment Income Support Scheme was linked to past tax returns also left recently self-employed individuals in limbo.
- Even for people who did have work, the absence of clear guidelines on how to hold employers who breach social distancing regulation generates a source of anxiety.

On the other hand, the particular threats unleashed by the pandemic also exacerbated existing vulnerabilities.

- The lockdown has had dramatic consequences for people on low incomes, who have been increasingly pushed into seeking help from food banks to ensure basic everyday subsistence.
- For those with minimal savings, losing their job also came with the very real risk of losing their homes when the eviction ban was lifted.
- Poor English and IT literacy, in turn, meant that they find it harder to access Government

support and information.

- Perhaps most dramatically, the fact that access to Universal Credit was tethered to applicants' abilities to evidence their living costs, systematically disadvantaged people who didn't have a written tenancy agreement and were paying their rent in cash.

In many ways, these new and widening vulnerabilities presented the charity with a test of its ability to transform itself. Volunteers were upgraded to staff status - which took hours of training, setting up the tech suited for working remotely, and bracing for the professional and psychological challenge ahead. Then there was the element of keeping up with rapidly changing Government advice, and putting in the work of cultural mediation - the effort to build bridges over the gaps in language, IT literacy, trust in Government and trust in self. As the adviser noted in the introductory vignette, redefining one's profession after decades in one sector, was a momentous psychological challenge.

Interviewing staff, there was a joint sense of humility before the scale of this crisis, and pride in the charity's ability to do its small part. Outreach became a weekly occurrence, as staff realised that, in a time of existential uncertainty, there was a need for both informed advice, and community. Every Thursday cross-team catch up calls would trail into the night, as staff took turns to share anecdotes, developments from complex casework, and plant the seeds of future projects.

Throughout this time, however, there was also the unshakeable realisation that, if the lockdown constituted a test of the charity's resilience, it also spoke to the deeply unequal politics of redistribution adopted by the Government. Lucky workers were furloughed, under a system which paid them more, the more they earned (up to the £2,500 monthly cap). The car washes, cleaners, and hospitality workers who sought help from the Work Rights Centre were simply dismissed. Their safety net was an ever thinning Universal Credit which, perversely, paid them less, the more disadvantaged they were - by informal housing agreements, or by their inability to decode the application. Without the ability to evidence rent costs, a single applicant would be expected to live off £400 a month.

Paralleling this inequality of redistribution, charity work under lockdown also revealed the systematic deficit of care, normalised by governance through austerity. Like other charities, food banks, and organisations that lent their support to those whose livelihoods were threatened by the crisis, The Work Rights Centre stepped into the void created by a thinning welfare state, and local authorities with the shrinking budgets. And in doing so it relied on private money, cautiously awarded by trusts, and the occasional corporate donation.

People with No Recourse to Public Funds Status

People with leave to remain but No Recourse to Public Funds (NRPF) status - refugees who are in the process of being resettled and unsuccessful asylum seekers - reported that they are stuck in limbo, unable to access social welfare support and fearful that accessing charitable or local authority services will place them under excessive state scrutiny that seeks to exclude or deprive them. They are also vulnerable to homelessness, and whilst almost all rough sleepers have been provided with temporary accommodation under the 'Everyone In' program, it remains unclear as to whether Local Authorities can lawfully continue to support those with NRPF, or whether they will receive any central funding to do so.^{xxxiv} It is possible therefore that many now face a return to the streets. Further, many people with No Recourse to Public Funds and non-EEA status don't understand their right to healthcare due to inadequate public messaging, preventing them from accessing hospitals if they fall sick with Covid-19. People with NRPF status can access statutory sick pay, jobseeker's

allowance, employment and support allowance, furlough and the Self-Employment Income Support Scheme. However, accessing such support requires that the person is employed formally, a condition that is not met by many of this population given the casual labour conditions that many are employed under (e.g. cleaners, taxi drivers), or the fact that many of these people are too old or too young to work. People with NRPF cannot access Universal Credit, leading to a further bifurcation between those with NRPF status and those on Universal Credit. Local Councils, however, have been aware of the needs of this population and in some instances have strived to support informal care providers, mutual aid groups and community centres where their needs can be met.

Beyond the Model Employer

Treasury policy so far has also operated by offering support to ‘business’ as a homogenous category. This approach obscures huge inequalities in size and resilience to economic shocks between firms. The outcome has been that the current business support policies are experienced as supporting larger businesses more than Small and Medium Enterprise (SME). Policies have also supported private equity business, indicating that it is not only the difference in size, but also the ownership and financial model that bifurcates opportunity for business support. Private equity firms often don’t have a business model that is concerned with whether the firm succeeds, but is concerned with how much capital they can extract, including through leveraging with debt before the ‘exit.’ These firms are lobbying for state backed funds by asking for their loans to be considered equity, when they use loans precisely because this means they do not need to pay tax. Treasury policies obfuscate and occlude these different kinds of businesses and their varying predatory nature—not all firms are interested in ‘creating jobs’ or ‘building recovery’. The pre-existing national nostalgia for the decline of the high street is implicit in schemes such as ‘Eat Out to Help Out’, which supports large restaurant chains who have the capital to weather the crisis as much as it supports small businesses.

Small and Medium Enterprises (SME)

SMEs are crucial to the social infrastructure of local and regional economies, yet they are experiencing precipitous losses of income (in some cases 80-100% of income), and those who run them are uncertain about how to maintain social distancing safely. Significantly, they are an essential part of communities, especially in socio-economically deprived areas. Their owner/managers are also highly motivated to save their firms because they are important to them financially and personally, and such enterprises are explicitly understood to be part of family and community projects.

Small businesses are hardest hit by public confusion and lack of trust in safety guidelines. The lack of clarity about reopening has translated directly into lost income, where client trust and confidence is a form of capital. Small businesses rely on personal trust as their unique selling point and are more vulnerable to situations where that trust erodes. Most people with small businesses are very anxious not to lose contact with regular clients, and working though lockdown was judged necessary to protect present and future income viability for some. SMEs often have higher sensitivity to seasonal income fluctuation than larger businesses, making confusion and uncertainty more damaging to overall viability. Welcoming clients back will involve rebuilding this trust by showing they are ‘trying to keep them safe’, for instance, by using sanitiser, masks and gloves. SME owners are making complex calculations of risk for employees and their families with respect to financial loss and exposure. Risks of continuing to work were being judged relative to client needs on the one hand,

and relative to wider family framings on the other, spreading income loss/relative risk of other family members' occupations. This is particularly acute where businesses require a higher than average degree of exposure. These include frontline care jobs; jobs where people could not suspend work because of permissions to continue; where they do not qualify for Government income support schemes, but are still exposed to infection (e.g. construction in London); jobs where physical contact is essential to the work and physical distancing is not achievable (e.g. beauticians, hairdressers, physical therapists, childcare workers, informal care workers, privately paid cleaners and private home-helps including for the elderly, disabled and frail).

Our research with small business owners suggests that there is a perception that Government financial support has been designed for big business interests, and the Government as having little understanding of SME needs or interests. The furlough system directly translates to jobs saved; however, policies are too 'broad brush': some kinds of business fell through the gaps. Many did not qualify for furlough and did not see small business loans as useful unless for replacement of essential equipment, because repayments would be a further drain on diminished income streams. The provision of business tax relief as an across-the-board measure has been designed for big business, where large supermarkets and delivery companies who have profited from the pandemic were given needless tax relief, rather than the money being targeted to those that needed it. Indeed, the cutting of business rates has shrunk the budget of local authorities, tasked with supporting the web of care provision at community level through the pandemic – examined in the previous section.

The Coronavirus Business Support Grant funding has directly translated to businesses, including one-person businesses, remaining viable; however, after tax it may be consumed by fixed overheads (including rent of premises) and not cover lost income. The threshold of rateable value of £51 000 for a business leaves many without support. Some larger businesses avoid this problem by 'bundling' their assets so each falls below this rateable value. The Government did not ask about ownership of businesses or attempt to identify bundled assets owned by a single wealthy individual. The requirement for personal guarantees (family homes) on some of the bank loans designed for business relief made them inaccessible to some. As with furlough, many have fallen through the cracks and there is anxiety about a sudden end to the scheme in an uncertain economy.

The loss of business will impact some communities more than others. BAME and migrant groups are more likely to run SMEs or family businesses, meaning the loss of income and employment will unequally impact their families and communities. Small and medium business owners of any ethnicity (including white British) may also be at increased health, social and financial risk because other family members often work in 'Covid-exposed' occupations. SMEs catering predominantly for any vulnerable group (e.g. gyms with specialist provision for older people; beauticians, hairdressers etc. with older clients) are disproportionately affected. These dynamics are likely to magnify existing regional inequalities. Relatively less well-off regions, such as the North East and Northern Ireland, have high proportions of SMEs compared to other regions in the UK. SMEs in Northern Ireland in particular are already struggling with Brexit uncertainties. Regional inequality in unemployment could be an immediate outcome of this Government policy, if not tailored to business size and business ownership structure.



Insights from the survey: Small Business

According to survey data, small business owners and self-employed people are commonly identified as vulnerable by those who are not small business owners/self-employed themselves. At times friends with small businesses are mentioned as the recipients of respondents' financial or physical support. In respondents' assessment of their well-being relative to that of others in their local area, small business owners are often singled out as those in relation to whom respondents feel relatively well off. In these cases, poignant rhetoric (e.g. 'small businesses have been destroyed') is often employed to underscore the plight of this group and to emphasise the perceived weaknesses of the Government's financial response to the pandemic. In measuring subjective well-being, the most significant difference between the average response of a respondent designated as either a small business owner or self-employed and the mean for the total surveyed population arose in measuring their compliance with the Government's social distancing guidelines in the past 7 days; small business owners and self-employed people rated themselves as less compliant. Several respondents wrote that business finance help and self-employed grants (provided by the national Government through local authorities) were especially important sources of external support.



Three people queue and one volunteer waits for food to deliver outside one of the new 'Children With Voices' community food hub locations on the De Beauvoir Estate in Hackney, 6th August, 2020. The Community Food Hub was evicted from the Wilton Estate Community Centre and now have 4 locations distributing the donated food.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund



Spotlight: Small and Medium Enterprises in East Anglia^{xxxv}

Fenella Cannell

Uneven outcomes and 'mixed realities' in an 'insulated' part of the country.

The initial effect of lockdown was a monthly income loss of 80-100% for SMEs in May 2020. Small employers, embedded in local communities, worked hard to maintain contact with clients while services were suspended, and avoid job losses. Furlough was crucial in enabling employers to avoid redundancies and allowed any available work to be directed to self-employed workers. Employers reported frustration at a lack of clear, timely and logical guidance and 'leadership' from the Government: 'we had to guess what to do'. A lack of realistic sector-specific guidance was linked to the impression that the Government modelled business policy on large businesses with high-spending lobbies only, largely ignoring realities for small and family businesses whose unique selling point is usually client trust. A specific example offered was the lack of any clear guidance from Government about when and how gyms would be allowed to re-open, which led to widespread client fears, especially among people of 40-plus, and steep business losses (e.g. one employer reported more than 63% membership cancellations in May as a direct response to Government messaging). Employers also mentioned a lack of nuance in financial support cut-off levels; many smaller operations missed out because of their rateable value was fractionally higher than £51 000 while some larger businesses were able to bundle their assets to benefit from these allowances through accountancy measures.

By August, the feeling in the region was that 'the pause button is off', but the economy remains highly uncertain. Locally, Covid-19 prevention now seemed 'incongruous' to some groups, while other people were still 'intensely anxious'. Both employers reported income recovery in August. Business A (a chartered surveyor) struggled with backed-up demand, which was driven by region-specific flows of money from bio-tech companies, as well as some wealthy groups moving out of London anticipating more working from home and less need to be in the city. Employer A had recovered lockdown losses but was 'cautious' about the upturn being sustainable. Employer B (a gym), who had struggled with the 'incredibly chaotic' messaging from the state and delayed re-opening, asked why food retail had been given priority over fitness when fitness helped save lives from Covid-19. Business B had been forced to lose two reception jobs. He stressed a repeat of the March lockdown approach would be 'catastrophic' and said furlough would be key: 'If Germany can do it, why can't we?'

Single-person service providers in the informal sector – working through lockdown

All self-employed independent workers welcomed furlough as someone in the wider family had benefited from it; however, many people reported problems falling through the cracks of Government financial support. Some workers who were able to work throughout (e.g. outdoors) reported stigma in being seen working. However, many cleaners and other informal workers reported clients being effectively heavily dependent on them throughout lockdown (and ahead of the Government's change allowing paid cleaners and nannies to work on from May 11th). These workers were already filling in for reduced council provision, and need has been increased by the freezing and closure of voluntary support services in high demand e.g. Age UK home helps.^{xxxvi} Informal workers' households were

often placed at the meeting-point of different policy pressures:

Example 1 - household with informal paid carer, in high demand, while extended family work in formal care sector, creating long-term problems with family unable to meet

Example 2 - workers with outdoor occupations e.g. gardener, builder, needed to work as did not qualify for sufficient income support, but in both cases had a family member with Covid-19 vulnerabilities and could not fully shield them.

Overall, we are seeing increased reliance on informal paid care in the context of a formal and imposed voluntary care deficit, discussed more fully in the previous section. In this context, single-person service providers found themselves at a pinch-point of multiple 'necessary improvisations'. Furthermore, respondents all expressed concern about those working in 'forgotten occupations', which is to say occupations depending on close contact who were still unable to earn income in August and with no date for re-opening given in Government guidance. Many of these people were facing the loss of their businesses.

A Screen for a Rentier Economy

Rent

Treasury support for 'the economy' has focused on subsidising labour for businesses. However, this focus on labour eclipses the role of rentier extraction and the burden of costs this puts on businesses and households. Over the past four decades, businesses have faced increasing burdens of rents, including but not limited to, those on property.^{xxxvii} These forms of rent extraction condense inequalities by directing wealth to the owners of 'assets'. Businesses in the hospitality sector note that the most significant difficulties they face are in paying rents to landlords, and that the Chancellor's 'Eat Out to Help Out' scheme simply allowed businesses to keep paying their rents. In the 'National Time Out' campaign, a coalition of over 3,000 businesses in the hospitality sector have been asking for a one year rent holiday. During the period of lockdown, there was no pause in the rents owed from businesses to landlords, only a pause in evictions. Businesses therefore still bear the burden of rent going forward, risking going into arrears. This is despite many landlords being eligible for mortgage holidays, which in some cases landlords have taken advantage of by using ongoing rents to save for deposits on further properties.

This significantly affected some SMEs we spoke to. One specialty shop owner explained that he was forced to close his business because he could not afford to continue paying rent to the landlord with the significantly reduced custom. He wanted to remain open, and had spent many years building up his business and relations with customers. However, he was explicit that he felt forced to close as he was not given the flexibility he would need with rent. His landlord was offering to defer some payments but not cancel them, despite the fact that his income in the future was not likely to make up for loss of income during the lockdown. This dilemma is being expressed by restaurants, pubs and specialty shop owners across the country, who note that Government policies show a considerable misunderstanding of how their businesses and the contemporary economy operates, with a significant proportion of costs consisting of rent.

A focus on labour and consumption has eclipsed the vast forms of rent extraction that have continued during the crisis, with landlords insulated from the economic difficulties emerging from Covid-19. This insulation of landlords, at the expense of business owners struggling to make a living, further

condenses wealth in the hands of already wealthy owners of assets. As noted in a previous chapter, conceptualising households as consumers eclipses the forms of care work that these entail, as well as struggles to meet significant ongoing costs paid in rent.^{xxxviii} Similarly, current Government policies are based on outdated models of the economy and occlude the significant ongoing costs that businesses are burdened with in rents. They also eclipse how the ongoing extraction of these rents further exacerbates inequalities by directing reduced incomes at a time of economic hardship, including those subsidised by the state through the 'Eat Out to Help Out' campaign, to relatively wealthy owners of assets.

Ownership

Moreover, singular policy schemes, such as 'Eat Out to Help Out', eclipse different forms of ownership, and the different business models these entail. These produce different forms of vulnerability, as well as different moral, social and economic understandings of risk. As illustrated above, SMEs felt many such policies were designed for larger companies not facing the same difficulties. Private equity companies who purchase chains using vast quantities of debt, such as the £900m leveraged buyout of Pizza Express in 2014 by a Chinese private equity company leading to net borrowings of over £1.1bn in 2018, receive the same state subsidies as small, family-owned restaurants. Such private equity models produce distinct financial vulnerabilities while siphoning capital to private equity owners through debt leveraged on companies, and interest payments to lenders. These business models are built on a proclivity for risk and the prioritisation of profits for private equity firms over the resilience of the businesses they purchase. Businesses are often weakened by the debt they are burdened with in order that funds can be siphoned to private equity managers - this business model produced precisely to minimise taxes. These entail different calculations of risk and obligation from those deployed by small businesses, who were placed in difficult positions by the pandemic while trying to support staff, with whom they are more likely to have ongoing relations. Small family businesses, such as those discussed above, struggle with unprecedented calculations of risk accompanied by acutely felt obligations to staff and kin relations, while large private equity owned chains actively produce significant risks through leveraged financial structures that entail forms of extraction. Moreover, large companies are more likely to be channelled through tax havens, pay out dividends to owners, while high levels of debt have been used by private equity firms precisely to avoid taxation. They thus already have a different relationship with the state and with the support that they may receive from it.

State support should be conditional on the ways in which companies receive and reciprocate this, for example by not paying out dividends during the relevant period, not having a history of utilising tax havens, and not using debt as a means of avoiding taxation.^{xxxix} At the other end of the spectrum, support should not be granted unevenly to companies who are specifically supporting particular party-political elements of Government, such as in the awarding of recent contracts without due tenure process. Treating 'businesses' as singular categories eclipses the different ways in which vulnerabilities of the pandemic are produced and experienced, and the different burdens of these risks.



Spotlight: Debt and Debt Advice

Deborah James

Prior to the onset of Covid-19, the problem of household debt in the UK – a nation facing the effects of a decade of austerity – had been widely documented and recognised. Despite relatively good provision of debt advice services, with many offering services that include communicating with commercial creditors and negotiating with them on clients' behalf to arrange for reduced monthly payments, and funded by creditors on the basis of a 'polluter pays' levy^{xi}, levels of debt were continuing to rise exponentially. In 2018 it was noted that the debts causing greatest concern were less those to 'the bank, the building society or the high-cost lender' than those to 'Governmental creditors enabled by new powers of enforcement'.^{xii} (In 2018-19, for example, Citizens Advice (CA) reported that 'councils used court action 2.3 million times and bailiffs 1.4 million times to collect council tax debt').^{xiii} The obligation to repay state agencies, especially the local authorities which administer some of the benefit system and collect council tax, had become equally, or even more, pressing than that to repay commercial creditors. Enforcement powers had also intensified as those authorities, with finances under threat as the austerity regime has cut their central Government funding^{xiii}, were in turn being forced to tighten up on these benefits, and to cut back on reductions in local taxes.

It was to be expected that household indebtedness would intensify as a result of the pandemic. And indeed, there is evidence that this has been the case. Again, the levels of debt reported by CA consist, less of straight loans from banks or high-cost lenders, than of monthly payments in arrears: from 2.8 - 3.4 million owing on energy bills and mobile phone or broadband payments, through 2.8 million owing on council tax bills, to 1.2 million owing on rent.^{xiv} As was the case before the Covid-19 outbreak, debts to the Government stand out as a particular matter of concern; in this case the figures show that such debts – and the costs borne for incurring them – are being felt unevenly. CA reports that:

People who are more likely to have been directly affected by coronavirus are more likely to be behind on their council tax. ...Of people who have fallen behind on council tax due to coronavirus:

- 79% have seen their income fall by 20% or more
- 63% are key workers, compared to 26% of those who aren't
- 65% are shielding or at increased risk of coronavirus, compared to 32% of those who aren't

CA also notes 'the high add-on costs of council tax debt collection' - bailiff fees added a total of £200 million on top of monies owed.^{xv}

In short, key workers, those who are shielding, and those who have had their livelihoods disrupted by coronavirus, are the ones that have already, disproportionately, been pushed into debt. They also risk the further escalation of unpaid bills – and worse.^{xvi} Advice agencies, however, have noted something of a lull in requests for debt advice. Instead they are being asked for help as unemployment and lay-offs loom, and anecdotal reports suggest that there has been a lull in people seeking debt advice since the furlough measures came into place. There is a sense that the major economic effects of the pandemic have been deferred because of the furlough scheme and the temporary bans on bailiffs and evictions. But advice agencies anticipate being faced with a 'cliff edge' of enforcement when the bans on bailiffs and evictions are lifted at the end of August. Anticipating

this, there have been calls for debt cancellation and for more or less major reforms to the UK insolvency system.

Conclusion: Supporting Livelihoods

The range of bifurcations between those who have access to Government income and business support, and those who do not, reveal that the Treasury's project has failed to support not only the diversity of employment situations of the UK's workforce and the nature of employment; but has actively favoured the middle classes who are more likely to have secure income and consumer power. This sector of the population is also more likely to have access to asset-based wealth and the means to weather the crisis. Those who do not have secure work and have lost employment or pay without being able to access furlough are forced to access Universal Credit. Indeed, the present moment differs significantly from the post-war or New Deal picture; casualised labour and financialised wealth have opened up deep economic divides that have been widened by austerity and now exacerbated by the pandemic.

Yet, in the Treasury project, the politics of productivity outstrip the politics of redistribution, and the buoyance of a productive economy built on middle class consumer interests is prioritised over the needs of all in a time of crisis. Meanwhile, the question of who is considered 'productive' is loaded with certain classed, gendered and raced ideas of labour that trivialise care and precarious work. In order to correct this imbalance, the Government needs to acknowledge the casualisation of labour and the decline of the wage as the status quo for the majority of people; and the need to support people across a range of different employment, or unemployment, situations. Hence, a measure of the UK's economic health would not be indicated by productivity or growth, as these indicators do not account for rising inequality, but should instead focus on redistribution and mitigating deprivation. Indicators would need to account for multiple forms of disadvantage that range generational divides, race, class, gender, region and ethnicity. Such health also cannot be captured through the unemployment rate; given the stagnation of wages, in-work poverty and its proxy child poverty are better measures.

Two 'fixes' for the UK economy in the aftermath of the pandemic have been presented by the Treasury, but we argue that these are short-termist, will further exacerbate rising inequalities, and will create greater socioeconomic problems in the long-term. Firstly, increased automation where possible may seem a seductive solution that reduces business expenditure on wages whilst also creating a more 'covid-secure' productive environment. A parallel movement would be an expansion of the 'gig economy' which similarly reduces pressure on business stemming from wages and related payments, also emphasising 'flexibility' in the labour force. Both of these possible fixes will have the greatest impact upon the lowest skilled workers, who our research shows benefited less from 2020's support schemes, such as furlough, than those in secure, waged, middle class roles. In the event of further lockdown periods, Government spending on furlough would therefore be unlikely to reduce, and instead we would see further escalations in social inequality, with asset-holders being largely unaffected whilst those already experiencing poverty or close to it will be further disadvantaged by policy and business choices. As well as increasing suffering, such inequality is amenable to developing into ever deeper social divisions and disillusionment with the state.

As concerns rise around the recession the UK is now facing, we are presented with an opportunity for revisiting our assumptions of how economic life in the UK functions, and indeed what the economy is for—we argue it should be for supporting livelihoods, especially of those most disadvantaged. Our

research has found that the ideal of the economy present in Treasury policy is unfit for the reality of economic life and livelihoods in the UK.



Short Term Policies (including for the second wave):

- Build better economic support packages, like part-time furlough, for a range of employment conditions by:
 - Ensuring accountability of employers in the furlough scheme to protect employees rather than rewarding them for retaining only some members of staff
 - Empowering employees with accurate and up to date information on the support available to them, their rights and how to access it
 - Funding debt and employment advice services to help people navigate the current conditions; these could be located in the new community recovery centres
- Assist the Livelihoods of Households in the Round by:
 - Creating more legal protections for informal sector and gig economy or precarious workers
 - Forgiving consumer debt and directing quantitative easing to support this
 - Providing comprehensive, visionary, adult education and retraining schemes for workers who have lost their jobs
- Support small business and counteract rentier capital:
 - Extending and expanding measures for rent holidays such as a rent free period for a time that a tenant's business is closed, and allowing tenants to pay rent as 10% of turnover instead of full rent
 - Attaching conditions to the receipt of Government subsidies. For instance, businesses using tax havens should not be receiving significant subsidies from tax payers; private equity companies whose business model includes leveraging firms with large amounts of debts in order to avoid taxation and extract money should not be receiving the same forms of financial support as small or family owned businesses
 - Funding local authority grants to support local infrastructures of SMEs and family businesses in the most deprived neighbourhoods

Long term policies:

- Investigate regional and other economic inequalities by:
 - Working to understand who is benefiting from policy initiatives and who is not by partnering with local authority economic policy officers
 - Assessing rentier, consultant and financial economies and the extent to which they have profited from the pandemic
 - Taking a centralised approach to regional regeneration through Government investment, particularly in family businesses and SMEs

- Apply a social calculus – replace measures of the health of the economy such as productivity and growth with attention to regional, community and household inequality and how it is deepened or reduced by Treasury policy:
 - ‘productivity’ will lead to a dead-end of automation and/or rhetoric of zombie companies which should be ‘allowed to die’, potentially devastating again post-industrial economies
 - ‘growth’ will lead to an over-emphasis on consumption-led growth modelled on supporting middle class households only through hard times
- Combine quantitative as well as qualitative research on the changes to the UK economy as a result of Covid-19 and policies of social isolation



Ziggy Noonan from the Children With Voices community food hub puts together bags filled with food, drinks and supplies for families in Hackney, 13th April, 2020.

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IV | Building Cooperation



Introduction

The only path forward in the second wave and beyond is to build cooperation between all the UK's communities, enabled by a robust local public health infrastructure, policies that support the public and co-creation from the ground up. However, political and media narratives have too often focused on blaming specific segments of the public such as multigenerational households or students for transmission events. The significance of building cooperation for renewal is underlined by the potential for the opposite to emerge from the pandemic—deeper divides underpinned by stereotypes and stigmas.^{xlvii} Policy makers and populations are operating with deep uncertainties and insecurities given the lack of scientific knowledge about Covid-19. In the UK, robust efforts have been made, particularly by Public Health England and the Office of National Statistics, to understand patterns of transmission of Covid-19. However, their efforts to collect data have, understandably, been focused on groups who are at increased risk of exposure such as healthcare and essential workers early on in the pandemic in the UK; and more recently on clusters of virus transmission in particular geographic localities where outbreaks occur. As a result, we lack a comprehensive, population-level picture of epidemiological patterns of transmission and evidence as to how certain behaviours, social situations and spaces contribute to it. As anthropologists have long pointed out, such uncertainty and sense of risk produces boundary making narratives and practices as people seek security. In addition, blame is attributed by technocrats, politicians and the public to explain social suffering. As we saw with the early years of the HIV epidemic, it is only through concerted attempts to push back against such narratives and practices that negative effects can be avoided. Yet there has been little public discussion of stigma, growing hate crimes, policing of social boundaries and attributions of blame at large now. This section of our report contains an open discussion of these divides and aims to build alternative strategies to forge social cooperation. These will go beyond communication to reflect on how this cooperation can be supported by active public health campaigns, co-creation and provisioning policies.

At present, the general population and people in policy-making processes are in a situation of uncertainty. As a result they are speculating about Covid-19 transmission and how to prevent it. Speculation involves the projection of an invisible order onto a radically uncertain future in order to anticipate or control it.^{xlviii} Our research has revealed that this speculation involves the perception of new kinds of risk – certain places, people and behaviours are associated with transmission; and other people and groups are associated with increased vulnerability to such risk. By dividing the world into people who are risk givers – or 'spreaders' of the virus – and risk takers – or those who are vulnerable to such spread – this perception of risk can work to polarise, exclude and stigmatise

certain groups.^{xlix} These perceptions shape people's decisions in the present - how they work to protect themselves and who they deem safe. This section will, first, highlight the uncertainty and anxiety that surrounds evidence and regulations related to Covid-19 among the public. Second, it will present evidence from our research as to the new ways in which risk is being perceived. Third, it will highlight the new relations of stigma that have emerged from this perception of risk. In order to combat these processes of stigmatisation and blame, it is necessary to build a fuller picture of how the virus is spread and how it is impacting people's lives; how they are responding to guidelines and perceiving risk.

This picture, we will argue, can be created through a stronger drive toward statistical data collection on transmission at population level, followed by a disaggregation of this data by various factors of age, gender, locality, ethnicity, income, deprivation and so on by the ONS and others. But most importantly, there should be triangulation of this data with systematic ethnographic evidence about how people are behaving in their communities. On these foundations, it will be possible to lessen uncertainty, co-create policy and build cooperation.

An Uncertain Present

In situations of uncertainty, people attempt to regain agency by following guidelines and assessing risk. Our research shows that Government communications and policies, as a whole, have not reduced uncertainty for the UK public. Instead, because of their variability, inconsistency and remoteness from life, they have intensified it.

Communication and Mistrust

Our survey and ethnographic interviews reveal that a lack of clear messaging from Government sources has left people without an understanding of social distancing guidelines and Government policy changes, and with a lack of trust in the Government response. This is particularly acute for those with poor English and IT literacy, and those who do not engage with mainstream media outlets. It is clear that people get information on epidemiology in a mediated way. This is sometimes through the media outlets, but most often through interpersonal interactions. Often, it comes through interactions with community networks, gatekeepers or trusted advisors. Grassroots community support services - often informal, cultural or faith-based and local - have been of critical importance in supporting isolated families, providing much culturally-specific information, advice in navigating welfare, health and financial support. If gatekeepers are lost, for instance, in male-headed households who have suffered the death of a provider; or in elderly households normally dependent on a carer or relative, others are cut adrift. Layers of communication between some disadvantaged groups and various health, financial and social support services have broken down due to the inability to communicate face-to-face. Some deprived communities are completely alienated from support and information services such as refugee- or migration-oriented services and some faith-based organisations. Empowering community networks to provide information at grassroots level is a possible solution, as in Hackney's embedding of community champions in a network of provision.

Groups' engagement with the Government information and guidelines are informed by existing relationships of trust and mistrust; such that some read the 'negative space' within the guidelines. Many are more likely to trust informal sources of information than formal ones. Different engagements with Government information lead to differential responses. For instance, those who believe the virus is a hoax are unlikely to adhere to guidelines, and see the pandemic as an affront

on civil liberties. Further, some communities indicate that they do not trust Government information sources or Government services to meet their needs, reporting bad experiences with professionals in the past, and hence are unwilling to do what is necessary to access health and social care.



Insights from the Survey: Government Guidelines

The distributions of regional location, ethnicity, age, employment and income amongst those who ranked the clarity of Government guidelines as very low did not vary significantly from the total surveyed population. Those who ranked the clarity of Government guidelines as very low, also ranked their life satisfaction in the past seven days and during April lower than the average. Those who said they or someone in their household had been leaving the house for work referred often to the stress and 'mental exhaustion' of making decisions to keep themselves and their families safe. Many elaborated that they thought the Government's response to the pandemic was misguided 'nonsense'.

In a situation of uncertainty and anxiety, the UK public has been presented with an array of guidelines that do not make sense because their rationale and connection to each other is unclear. Changing policies such as 'Eat Out to Help Out' or 'the Rule of Six' have perhaps worked well as single slogans as part of a single campaign when measured in a particular point in time through focus groups. However, people experience Government messages as a whole, and in relation to each other, over a period of time. Therefore, although individual campaigns may have clarity, they jostle with contradictory messaging. Unless an underlying rationale that connects them is made visible, the public's uncertainty will be increased by Government communications and measures, rather than reduced by it. This is likely to lead to a cycle of intensifying distrust and lack of compliance. Significantly too, Covid-19 regulations will not reduce uncertainty unless they relate to people's lives in a meaningful way and are embedded in an ethnographic understanding of their concerns. These barriers cannot be overcome alone by creating community champions, drawing on local leaders or peer-education. These may help, but unless the Government has a consistent strategy in relation to Covid-19, underpinned by a clear rationale over the long-term, this will not advance credibility. In addition, the Government needs to take seriously projects of local co-creation, participatory mapping and ethnographic engagement as valuable sources of policy.

New Perceptions of Risk

Government policy and regulations around Covid-19 have generated new perceptions of risk among the public that are lived intensely as vulnerabilities. These are often confusing and difficult to navigate alongside the need to make a living, connect with others, or Government messages that 'the economy must come first'. These perceptions do not match the usual categories in public health of compliance or non-adherence. Instead risk is lived as a series of dilemmas about how to act safely in relation to others in your social networks. It is a peopled risk, that makes us think of ourselves as a particular kind of person in relationships. It involves therefore a social and ethical imagination of how to act. By coming closer to this lived experience of risk, we can build more effective and convincing policies.

For instance, the designation of people as 'clinically vulnerable' and the necessity of 'shielding' have

calibrated people's experience of risk during the pandemic, in relation to others who are not deemed such. Perception of risk is a barrier to many conducting their usual social activities; for instance, elderly people are less likely to volunteer to provide services because of their increased risk. Though there is a significant sense that some feel that they are 'not vulnerable enough'; and hence are reluctant to ask for help. The designation of 'essential workers' has forced people to consider their own appetite for risk as they remain at work. ONS evidence surrounding the disparities in the impact of Covid-19 of different groups, such as men and BAME groups, has shaped people's embodied experiences of their ethnic and cultural identities.¹ As a result, we have seen a new 'epidemiological consciousness' emerge in during the pandemic that has reshaped the way in which people relate to others and to themselves.



Insights from the Survey: Clinical Vulnerability

Importantly, people have self-diagnosed themselves as being 'clinically vulnerable' - with 442 (out of 3,599) respondents reported that they or someone in their family considered themselves to be 'clinically vulnerable' - although they had not been instructed to shield by the Government or a doctor. In comparison, 427 people reported that they or someone in their family had been advised to 'shield' by the Government or a doctor. The most common reasons given for self-identification as 'clinically vulnerable' included (in order): asthma, diabetes, heart conditions, pregnancy, age, weight/high BMI/obesity. In this cohort, the average respondent ranked their own adherence to Government social distancing guidelines as higher than the average within the total surveyed population. Their confidence in others' adherence to Government social distancing guidelines, in the 'Test, Track and Trace' system, and in the Government's coronavirus response was lower than within the total surveyed population. Distribution across region, ethnicity, and income level was representative of the total surveyed population.

Respondents in this cohort consistently reported the level of risk that coronavirus posed to health as higher than the average risk assessment amongst the total surveyed population. In contrast, they ranked the risk of lockdown to well-being lower than the average - especially the risk to 'rights and freedoms as a UK resident'. This suggests that those who identified themselves or their family as 'clinically vulnerable' generally perceived the pandemic primarily as a crisis of physical and public health, rather than as a primarily social or political issue.

Based on this evidence, some members of the UK public have actively dealt with their fears of Covid-19 by choosing to adopt the label of 'clinically vulnerable.' They are now calibrating their risk accordingly. While this may seem like a public health success story; it raises the question of whether the model of adherence can capture this reality in which groups who are not designated 'at risk' actively define themselves as vulnerable to cope with uncertainty. This is a point brought home by the different experiences of shielding individuals who saw the new epidemiological category applied to them as a negative rather than positive imposition.



Insights from the survey: Shielding

On average, shielding respondents ranked their experience of lockdown relative to that of others in their local area as significantly lower than the total surveyed population. Many expressed anxiety and frustration relating to existing conditions and illnesses that were unrelated to Covid-19, but had become more difficult to manage with limited access to medical facilities and support. Notable examples were those diagnosed with cancer, diabetes, and severe respiratory problems. Many emphasised the toll isolation from friends and family had taken on their mental health. Several who ranked their experience very low exclusively stated 'shielding' or being 'vulnerable' as explanation, without mention of family or external support. Frustration was particularly poignant when shielding individuals compared their experiences of the pandemic with those of non-shielding people in their area, especially regarding freedom of movement and exercise. From the survey responses, it becomes clear that social support, even minimal communication through internet, phone calls, was crucial for those shielding to keep 'dreadful uncertainty and anxiety' at bay. This became even more important as the shielding regulations were loosened in August, people shielding were left with a sense of incomprehension as to why such strict rules had suddenly been suspended and they were being encouraged to return to workplaces. Suddenly cast adrift from guidance, they were left in a situation of intensified anxiety.

Therefore national and local restrictions have created a situation where 'over-adherence' occurs among less vulnerable groups and despair and uncertainty besets shielding groups. Clearly plans to segment populations from each other to contain infection such as the elderly or the vulnerable have a hidden social cost—over-anxiety and despair. This needs to be acknowledged and people need to be better supported through restrictions and guided more thoroughly when they are lifted. When restrictions are applied there should be a related expansion of mental health provision and support along with wider access to individual medical guidance. This could be provided by GPs, peer-educators and paid community champions, mental health charities and professionals. It should be funded by the Government as a matter of urgency. As we will see, this is particularly important because social restrictions have generated an epidemic of people self-identifying as suffering from mental health issues or fearing for the mental health of others as they deal with intensifying uncertainty.



Michelle Dornelly, the founder of charity Children With Voices, tries to make some space in her living room that has been overcrowded with donations for the last 8 years. Michelle is trying to find a permanent space with a kitchen for her community food hub, but has grown frustrated with the level of support from Hackney Council. She has launched a GoFundMe campaign to raise the money.

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A Mental Health Pandemic

Across all our data sources, our informants feared risks to their present and future mental health. This was triangulated with other forms of disadvantage such as income loss and calibrated primarily by the level of social isolation that a person was experiencing. Critically, studies show that rates of depression in adults in the UK have doubled during the pandemic.^{li} Scholars have called for urgent research into the ways that structural inequalities are contributing to this wave of mental distress.^{lii}



Insights from the Survey: Mental Health

In general, 'mental health' was employed by survey respondents as a stand-alone term; respondents often said that lockdown had affected their 'mental health,' with little further explanation and with an undoubtedly negative connotation. While diagnosed mental illness, depression and anxiety were presented by many respondents as preconditioned risk factors that impacted people's experiences of the pandemic, most related these conditions to friends, relatives or the general 'public' rather than to themselves. In contrast, 'poor,' 'affected' or 'declining' mental health was often cited by respondents as a personally experienced symptom of the conditions of lockdown. People often referred to their own state of mental health as if on a sliding scale, stating or implying that others are certainly worse off; for example, one middle-aged woman felt 'mental effects [were] starting to show after three months' despite the fact that '[she is] a perfectly healthy person with no mental health issues'.

'Mental health' seemed to signify a number of emotional and behavioural patterns, most frequently varying formulations of 'loneliness' often made more poignant by stress, anxiety, and uncertainty. It was often implied to be the opposite of or antithetical to lockdown, or to be a necessary trade-off for overcoming the outbreak; for example, one respondent asserted that 'we need to care for the mental health of many people, but I am concerned that opening things up too fast is dangerous'. In sum, 'mental health' was generally portrayed as a social condition, imperiled by isolation from meaningful social contact (both casual and practical/work-related); this applied to people's reflexive characterisations of personal experience, as well as their perspectives on others' experiences of the pandemic and lockdown.

Respondents had varying verdicts on the effectiveness of online and remote mental health services, with some finding 'meeting virtually too different to in real life'. Acute episodes of mental illness or 'breakdown' seemed to be prioritised for in-person or quick-response treatments, while low-level or chronic experiences of 'poor mental health' were not quickly addressed by health authorities and were almost entirely virtual. New users of mental health services were particularly dissatisfied with virtual mental health support. Notably, several respondents mentioned seeking out private mental health care because of a lack of availability and of policy supporting the expansion of NHS mental health services.

Mental health was often mentioned as an issue on which Government authorities and policymakers had been conspicuously silent to the point of negligence. It was used as a signifier of the Government's inattention to problems less tangible and quantifiable — and therefore considered less pressing and less manageable — than the number of virus-related deaths or infections. Many expressed general concerns for the mental health of people publicly considered most susceptible to

the negative effects of lockdown, including the elderly, children, young people and disadvantaged groups. Those related to or living with health workers expressed concern for their loved ones' current and future mental health; for example, a mother worried that when her daughter, an NHS nurse, 'gets a chance to process all of this that it will affect her mental health gravely'. Partners of health workers were also clearly affected by their high-risk occupations.

Many insisted that mental health, not just physical health, should have been central to the Government's pandemic response and made part-and-parcel of lockdown policy. Amongst the survey respondents, there seems to be an overarching correlation between a lack of trust in Government and Government policy, and the incidence of 'mental health issues' arising or exacerbated during lockdown. Many who rated their confidence in the Government's handling of the crisis and in the Track & Trace system very low expressed the notion that 'for the vast majority the risks of a prolonged lockdown/period of isolation exceed the risks of Covid'. Accordingly, many elaborated that mental health concerns should be considered a valid criterion for prioritisation in re-opening and the easing of restrictions. Certainly there appears to be a mental health pandemic in the UK accompanying the Covid-19 pandemic that needs to be addressed by provision and increased resources at the local level as soon as possible.

New Relations of Stigma

The polarisation between those who are vulnerable to the virus, and those who are perceived to spread it, is manifest in new forms of stigma. Stigma indicates a relation of fear and anxiety that provokes others to avoid or build boundaries against another who is perceived as polluting, contagious or dangerous. The lack of scientific information or behavioural evidence as to relations of transmission results in speculations as to who these individuals or groups are based on preconceived stereotypes or new social divides. Such attributions of blame result in avoidance behaviour, deepening social divides between groups and generations. The experience of stigma can be perceived, anticipated or internalised; shaping the way in which people interact with each other and see themselves.

The fear of exposure to the virus, of rising case numbers in particular geographic areas, class groups and ethnic communities, is manifest in the apportioning of blame in 'hotspots' of transmission, or the accusation that certain ethnic, cultural groups or age-groups are 'vectors' of transmission. Most importantly, Government advice, communications and policy decisions can perpetuate some forms of stigma, where, for instance, the lockdown of particular ethnic areas or prohibition of certain religious activities serve to cement them as potential sources of infection in the public imagination. Some of these new relations of stigma that we have observed include: (1) stigma against essential workers, both during the lockdown as they continued to work, and as lockdown has eased, as they were excluded from social bubbles and alienated from some social networks; (2) stigma against multi-generational households; (3) stigma against young people, where young people are considered dangerous due to their 'reckless' behaviour, the fact they socialise without being socially distant with a range of people, and may be a-symptomatic if they contract the virus; (4) stigma against black and ethnic minority people, where multigenerational households and key workers are conceived to be mainly BAME, these groups are seen as non-adherent or unable to understand Government guidelines; (5) stigma against low income or deprived communities, considered to have poor hygiene practices and cramped living conditions where the virus could spread easily.

Language of Stigma

Moral languages of pollution, hygiene and recklessness have been used to apportion blame to certain groups. Avoidance of stigmatised populations is often articulated through the oblique language of safety and protection, rather than illness or infection. Conversations about safety are used as a proxy for conversations about transmission and epidemiology; where the language of protection takes the place of the language of illness and infection.

Certain symbols or practices - such as mask-wearing - have served to perpetuate stigma. The collective responsibility to wear masks was not promoted from the outset, leading people to associate it with a divergent range of attributes. The mask has become a complex symbol. In some places it is worn by all and is linked to protection and good citizenship; and in other places it connotes illness and is associated with avoidance and exclusion. Masks have been associated by some with social policing against those not wearing them and the undue extension of Government authority in some cases. There are instances where the mask mandate has been indicated as giving police a means to harass minority or young people. In others, there is more subtle avoidance behaviour of those who do not mask. These new languages have spread fast on social media such as TikTok, where films show policemen going onto buses to check masking, for example.

Such issues should not be simply considered in terms of adherence/non-adherence and a problem of communicating behaviours. The material culture, categories and practices of the pandemic have become complex signifiers of risk and danger provoking visceral and socio-political responses. Any intervention around these needs to acknowledge this rather than ignore it. Policies need to positively build images and practices of collective cooperation, while explicitly combating stigma. We now address three spotlights on the BAME category, Multigenerational Households and Essential Workers that illustrate emerging Covid-19 categories of stigma and ways to move beyond these. This is followed by a detailed case study of Leicester, and the uncertainties people faced there, during continuing social restrictions.



A homeless man reaches through the window to take a mobile phone from staff inside the Dr Hickey Surgery, a medical practice specialising in healthcare for the homeless in Westminster, London, 3rd April, 2020. Due to the coronavirus pandemic and social distancing guidelines, all consultations are now done over the phone. Patients only enter the building for urine samples and to make a picture for registration.

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Spotlight: The BAME Category and Ambivalence

Nikita Simpson

A number of the categories used to form policy during the pandemic have circulated in public discourse and shaped public imagination. One of these categories is the Black and Ethnic Minority (BAME) group. Prior to and during the pandemic, the UK Government's design of policy has not always worked to meet the needs of BAME communities. A lack of consideration of diverse living and working conditions, mental and physical health needs, social support structures, English literacy and digital access and capabilities have intensified the existing disadvantage of some ethnic minority groups, and rendered others disadvantaged or vulnerable in new ways. For instance, in relation to food provision, food packages do not take into account the dietary habits and requirements of some BAME communities, resulting in many recipients returning food to food banks. Poor English and IT literacy has made it difficult for people to cash in food stamps and Free School Meal vouchers, leaving them reliant on family or community mutual aid to navigate the system. Disparity in the impact and efficacy of policy is compounded by, and contributes to, disproportionate exposure to Covid-19, morbidity and mortality.

Not surprisingly given this social reality, responses among our informants as to the new ubiquity of Government concern with BAME groups and risks to them in the pandemic were highly ambivalent. Many interlocutors eschewed the category altogether, preferring more specific religious, regional and ethnic identifiers. Other people who did identify as BAME understood the statistical suggestion of increased risk to their community in two ways. On one hand, interlocutors indicated that they have experienced a heightened sense of fear for those in their community, and a self-perception of clinical risk. BAME keyworkers, particularly those who lack seniority in their workplaces, are experiencing significant stress about their exposure to Covid-19. Though often unsure of the cause of such clinical vulnerability, many speculated that it might be due to their genetic predisposition and the high incidence of non-communicable diseases such as diabetes caused by their 'lifestyle and diet'. This showed that the category of BAME, as used in Government discourse, has been internalised by some in this community and shaped the way they perceive their own bodies.

On the other hand, other interlocutors reacted against this ethnic generalisation, suggesting instead that high exposure, morbidity and mortality was caused by environmental disadvantage and deprivation. Interlocutors who expressed this line of argument were more likely to be from a higher socio-economic status, earning higher incomes in white-collar professions. However, most BAME people were very concerned about the media coverage and stigmatisation of their communities as vectors of transmission; and the perception that ethnic minorities are not able to understand or abide by rules. Social distancing is perceived to be enforced too severely and unequally on some BAME groups such as young black men; in a manner that is reminiscent of 'stop-and-search' policing. Some chose to identify with the BAME category in relation to their medical risk profile, but eschewed it as a category that described their social positionality, or their culpability as vectors of transmission.

Between BAME respondents there were social divides in relation to the apportioning of blame for transmission. In many communities, cultural logics of cleanliness, hygiene, purity and pollution have been transposed onto adherence behaviour and risk of transmission. This is associated with long-standing historical ethnic, religious and class divides. Indeed, often respondents would push back

against the stigma apportioned to BAME groups by recasting blame according to class lines; for instance, by indicating deprivation and crowded housing as a vector of transmission; or indicating highly mobile better-off people as a vector of transmission.

More hopefully, although stigma has increased in some communities, and social divides have widened, the provision of aid by cultural and faith groups across communities has fostered interactions that otherwise would not have occurred and new knowledge/acceptance between communities. For instance, the provision of food through a local mosque in Hackney has allowed for unprecedented interactions with non-Muslim food recipients, leading to more support from local MPs.



Insights from the survey: BAME Respondents

47.87% (90/188) of those who identified as an ethnicity other than 'white' (South Asian, East Asian, Black, Mixed, or Arab) lived in London, a far greater percentage than among the total surveyed population. 14.89% (28/188) reported that they did not have access to a private garden or balcony where they are living. 14.89% of BAME respondents reported that they had experienced a bereavement in the past three months, compared to 11.90% of the total surveyed population.

BAME respondents ranked their life satisfaction in March 2020 (before the pandemic) as lower than the total surveyed population. More significantly, BAME respondents demonstrated a lower disparity between their life satisfaction in March 2020 and in the week before taking the survey (late-June 2020). On average, BAME respondents ranked their life satisfaction directly before taking the survey lower than in March 2020, while in the total surveyed population satisfaction fell.

When asked to assess the threats they think coronavirus and lockdown pose to themselves and others, the largest discrepancies between BAME responses and those of the general surveyed population were found in perceived threat of lockdown to 'rights and freedoms as a UK resident'. On average, BAME respondents ranked this threat *lower* than the total surveyed population ranked it.

Overall we suggest that in public policy, communications and strategies of community engagement the BAME category is disaggregated. Instead vulnerability to Covid-19 should be mapped as a series of structural factors that intersect to create greatest disadvantage for those groups who are most excluded and least economically prosperous in each social situation. This means attention has to be paid to within ethnic and religious group inequalities as much as to between group inequalities, such as those of different denominations, gender and age. Any community engagement must actively seek to see the community from different vistas within it before co-producing policy. Rather than focusing on important community leaders alone, marginalised groups within communities should also be approached as local experts. This kind of work can only be done if it is grounded in local institutional settings and their expertise - we suggest that this is built from the proposed new community recovery centres through forms of co-production, but that it must also come through deep engagement with a wide range of already existing local authority, funded mutual aid and support structures, such as those outlined in section II of our report.



Spotlight: Beyond Blaming the Multigenerational Household

Laura Bear

The multigenerational, especially BAME, household is assumed within media coverage in the UK to be an important site of transmission. This assumption began in June-July 2020 as social restrictions were applied in Leicester and other towns such as Rochdale, Oldham and Bransford in Darwen. An association between this household and BAME groups, especially Muslim people, was also reinforced by the announcement of restrictions on households mixing on the eve of Eid. This continues within recent coverage of debates about Tier 3 measures in places like Manchester where household mixing is cited by city leaders as one of the most important sources of transmission, more important than bars and restaurants. These media narratives fundamentally misunderstand the nature of data on transmission and what households are. They also transform a public health policy concern with the vulnerability of multigenerational households into a blame narrative. It is very important that policy makers and politicians do not reinforce these blame stories, or rush to conclusions about household transmission. Otherwise they risk reinforcing social divides and will leave a legacy of fragmented, distrustful communities.

How do these narratives misunderstand the data on transmission? Our data on clusters come from the national track and trace system. When individuals are asked about contacts it is very easy for them to remember and name their family members and kinship groups. However, in public spaces they are less likely to know contacts and not all public spaces keep careful records of named people. In addition, multigenerational households are visible as dense clusters, whereas smaller size households may have transmitted Covid-19 to other people in public, but they would not know that they had done so as they are not connected in any meaningful, social way. In the framing of public health testing, track and trace, therefore, multigenerational households are disproportionately visible as clusters. Perhaps even more significantly, our data on transmission is a product of where attention has been directed at different phases of the pandemic in the UK. So, for example, in the early phases we have a lot of data on health workers and care homes as their testing was prioritised. Similarly, we have a lot of data on BAME multigenerational households in places such as Leicester because these areas became targeted spotlights of testing and tracing. Even if we had tracked the pandemic at a different stage in the same place, such as Leicester, it would have been circulating around different communities at different points in time. But this does not necessarily mean that these households and communities are the only or most important sites of potential transmission. It simply means that we have a snapshot of a specific point of time in the circulation of a virus within social networks. For example, if we had targeted testing on upper white middle class people returning from ski resorts in March 2020, we might have concluded that wealthy middle class sports enthusiasts and their families were a 'dangerous' household group.

On the question of BAME households, the evidence for them being particularly significant sites of transmission, as a recent SAGE evidence paper^{liii} argues, is, as yet, unclear (although the ONS is investigating mortality figures). This is due to a lack of data, both within the UK and beyond, on household transmission as a whole. To know if BAME multigenerational households were a particular site, we would need to compare in a controlled way through mass testing other kinds of households over the whole arc of a pandemic wave unfolding over time. We quite simply cannot

know this with the data or testing regime that we have at present. Although we can track their vulnerability to Covid-19 through mortality and census data, this is not a sign that they are a source of transmission.

If we are to think about household transmission an alternative approach should be taken, as recommended by a EMG SPI-B paper.^{liv} Household overcrowding and the environmental qualities of housing are much more likely to be vectors of significant transmission than other factors. Ventilation and the ability to isolate ill family members are crucial factors in whether any illness is passed on within homes. In addition, if we are to investigate household transmission, it should not be in terms of any essential quality of households. Instead, it would be better to analyse households on a spectrum of highly networked to low networked, and to test if highly networked households had any greater number of clusters of transmission than others.

It would be much better to focus public health communication efforts on changing all of our behaviours at home to Covid-safer ones; and to target, in particular, a range of households at risk because of their interactions in the public realm (for example in workers low paid, exposing jobs such as food plants or health workers) and households that are overcrowded with poor environmental conditions. It would also be important to particularly communicate to middle aged and elderly members, women who provide child-care and cleaning and domestic workers who are more exposed to contagion in the home, low-paid, precarious and key/frontline workers in highly networked occupations and disabled people and their carers. These communications should advise hygiene, rotational meals, domestic cleaning and other care practices that can ameliorate within household transmission.

Most significantly, to prevent narratives that entrench already existing social divides in a time of anxiety, fear and uncertainty, the media and politicians should stop highlighting multigenerational households as sites of transmission; and they should not imply that these 'problematic' multigenerational households are BAME. Communications should state that when people become unwell with Covid-19 it's because they are members of hardworking families who care for members of their communities. They are taking the risk of keeping the country and communities going and because of this they may become unwell through exposing situations.

The Risky Dilemmas of Key Workers

'Key worker' is a new category that has emerged from the Covid-19 situation. While this label has given a new heroic visibility to logistics workers, teachers, supermarket employees, care workers and medical employees, it has done nothing to remove stigma or raise their status in their workplaces. In fact, they face risky dilemmas and are seen as a vector of risk by other members of society. Many respondents who worked in retail or customer service expressed frustration about clients' failures to adhere to masking and distancing guidelines, generally framing this neglect as carelessness or lack of respect rather than a gap in the public's education. The following excerpt exemplifies a common response from those working in retail and customer service: 'I work in a DIY Shop. Customers do not social distance, nor do staff. Staff have been provided with PPE (gloves, face visors, masks) and 99% of them do not bother wearing it, including the Store Manager'. Those working in care-related fields, including support workers, social workers, teachers, and medical staff, generally do not blame their patients or students for lack of adherence but rather state the situation with little inflection of blame; in these cases, complaints most often highlight the lack of adequate PPE, of guidance from employers, and of Government guidance on workplace protections. Amongst

teachers there is an additional, specific fear of contact with the children of key workers; the vast majority feel they have not been sufficiently protected within the workplace and overlooked by Government policymakers. This feeling of neglect was often accompanied by poignant feelings of responsibility for the wellbeing of family members whom they could potentially infect by 'bringing the virus home.'

On the other hand, although they keep essential services going and are taking risks for us all keyworkers are seen as risky people by others and as potential transmitters of Covid-19. Among more highly educated respondents, a bias against essential workers was evident. For example, one respondent describes that because key workers in her area 'have to go out and work to pay the bills anyway, hardly any of them follow social distancing guidelines, to my [elderly] mother's alarm'; this respondent cites her mother's experience with healthcare in Germany and her own university-level education as reasons for their own deliberate adherence to the guidelines, pointing to a greater rift in public opinion corresponding to perceived educational inequalities. Such blame has also been levelled at those who work in the caring professions. For instance, risk perception and fear around the virus led some parents to feel that sending their children to school or pre-school was selfish and reckless, and some childminders remaining open to care for the children of key workers were accused of pursuing self-interest by staying open and increasing the community's risk.

As with the multigenerational household, such divergence in public opinion can only be overcome through a concerted emphasis on risky situations rather than risky people. It should be made clear that if employers live up to their responsibilities for providing Covid-19 safer workplaces then risks of transmission will be low. If collective critiques are to be made these should be of environments of work and the irresponsibility of employers who are not taking care of their employees. Alongside this, there could be a different kind of heroic emphasis and concerted Government communications on key workers as people who take risks for all of us to live our lives. This group extends far beyond the already deservedly celebrated NHS and Teachers, into lower status work in childcare and supermarkets etc.



Chaveirim volunteers Yoni Koppel and brothers Yanky and Ari Lieberman unload the car at the Royal London Hospital, 6th April, 2020. Chaveirim is an organisation comprised of 56 volunteers on call to help the community with emergencies such as tyre changes, water leaks, and lockouts. During the pandemic they mobilised to deliver drinks and snack packages to NHS staff working on the frontline in hospitals around London.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund



Case Study: Leicester Local Lockdown

Nikita Simpson, Nicholas Long and Laura Bear

Leicester was the first city to become an area of national intervention on 29th June, 2020. Restrictions were re-introduced in the protected areas including school re-closures, except for the children of key workers; closure of premises and businesses; and restrictions on movements, gatherings, and interactions between households. Various exceptions were made, such as for funerals, provision of voluntary or charitable services, and caring for vulnerable persons. The city was unable to return to normal trading along with the rest of the country as planned on July 4th. New powers for councils to decide upon the type of closures required for future interventions were announced on 17th July.^{iv} Leicester has never had these restrictions removed.

Leicester is an important case study as it illustrates the impact of localised social restrictions on the perception of a place in the national imagination, on the self-perception of local residents impacted by the lockdown, and on their way of life. The challenges of this place have become those of many other Midlands and Northern towns, and in the second wave most of England with the recent Government Tier 2 restrictions. Much has been done to combat these by the local authority and public health officers at all levels since our research in July. Our picture captures the frustrations and confusions of populations before such efforts. These innovative practices need to be further studied, as they have forged new approaches in the mettle of the pandemic. Our snapshot shows the uncertainty that people would be left in if they did not receive this careful engagement from local authorities and public health officers.

Our case study is based on ten semi-structured qualitative interviews with people located in Highfields, Evington Valley, Belgrave, Central Leicester, Oadby & Charnwood conducted between July 15th and August 7th. Respondents in our study were identified through existing long-term research contacts with communities or by direct outreach. The interviews described here were with members of Hindu, Christian, Sikh and Muslim faith groups, and with people of White-British, Indian, East-African Indian and Sri Lankan ethnic backgrounds. Respondents included local counsellors, trade union representatives, faith leaders, third sector workers, small business owners, university lecturers and carers' representatives. In this report we have cross-checked the findings from the Leicester interviews with our survey of 550 Leicester residents; a nation-wide survey disaggregated for Leicester respondents; relevant elements of our broader research; and our long-term ethnographic work with similar communities. We use our findings as an exemplar of similar uncertainties when interventions are imposed and suggest possible steps towards better acceptance of social restrictions, more effective communication and responses to test, track, isolation and trace.

Overall we intend this case study to be an example of the kind of rapid action research that could accompany the introduction of local restrictions in order to map communities, trace emerging frontiers of stigma and support local public health responses. This could be part of a regular Government response led by local public health officials in collaboration with universities and local third sector and mutual aid organisations. This would, of course, be part of a new greater provision of financial resources to local public health infrastructures and to councils. As is clear from the current controversies over the introduction of Tier 2 restrictions in England, in places such as Manchester and Liverpool, we need an evidence-based, ground up approach to public health interventions that should be guided, not by politics at the regional or national level, but by a mapping of the social situation. In fact this case study was carried out very rapidly in collaboration with PHE and the local authority, and fed into decision making in Leicester, as well as a SPI-B paper on local social restrictions. It did not take many resources, but it did need an ethnographic understanding of the complexity of the UK's 'communities' and of the variety of local experts that needed to be consulted.

Legitimacy of and Uptake of Restrictions

There was a sense across all communities that national media coverage of the local lockdown, and particular issues surrounding it, such as the precarious working conditions of garment factories, was stigmatising for Leicester as a city. Survey responses and interviews with residents of Leicester city showed that the intervention was highly divisive: people felt that they had been ‘forgotten’ but also had become the ‘Lepers of Leicester’ or the ‘Pariahs of Leicester.’ They felt ‘ashamed’ and like the ‘laughing stock’ because they were still in lockdown after the national day of lessening of restrictions on 4th July. National media coverage about this made them feel left out from a national story. The lockdown, because of its name and its targeting on Leicester was understood as a ‘punishment’.

Across the Leicester region, respondents expressed a pervasive frustration with others in their area who were ‘not taking this seriously’ and with the lack of consistency in local and regional compliance with Government guidelines. While this presented a common aggravation, it seemed that the intonation of blame in the county fell most heavily on media and certain groups (especially ‘young people’ and ‘rioters’) considered non-compliant, while amongst city residents the Government was considered to be (often solely) responsible for lack of clarity in public health messaging.

The extension of lockdown had a negative impact on the wellbeing and mental health of people living in Leicester. All groups said they were experiencing despair at the fact that they had to continue with restrictions beyond the 4th July and they were losing hope, as there was no goal (the previous lockdown hadn’t worked) or clear end-point. The disruption meant people lost a sense of control as they had to cancel plans overnight, causing financial expense (cancelled holidays, dental, medical appointments, statutory leave that could not be regained) and potential ill-health as these could not be easily rebooked.

Door-to-door testing was seen as a ‘double edged sword’, as it had encouraged people to engage with testing and overcome barriers to access; but also had the potential to stigmatise certain areas and the groups who reside in them. Amongst the Muslim community, respondents suggested there was a small population who are unwilling to get tested because they do not want to share their biological data with the Government. The recruitment of volunteers for testing efforts was perceived as ‘too late’. Instead informants suggested that a strong drive for volunteers should be made well in advance of a second wave.

Support from National and Local Government

The easing of lockdown in some areas in the counties and not in Leicester city was perceived by some as a politicised decision by the central Government. Tension between local and national authorities was perceived by some respondents, related to the sharing of data and authority to implement restrictions. Respondents tended to put trust in either national Government at the expense of local authority, or vice versa. The non-adherence to restrictions by prominent national and local Government figures had impacted trust in Government and perceptions of lockdown’s legitimacy.

In the nation-wide survey, those living in the Leicestershire counties more often cited the ‘UK national Government’ as a primary source of external support; several listed the national Government as their *only* source of external support, unlike respondents in the city who occasionally listed ‘UK national Government’ only alongside other sources of support. The predisposition amongst county residents to support the national Government and the PM also manifested itself in the form of an anti-media bias; for example, a 58-year-old white woman living in the county who listed ‘gov.uk’ as a primary source of advice during lockdown reported feeling ‘the frustrations of journalists twisting what is said regularly. Whether it’s is bbc or itv, [it’s] all the same’. Similarly, another county respondent expressed that she felt ‘the media coverage has been dismal. All they are interested in is sensational journalism and attacking the Government’. A 64-year-old white woman also living in the county

responded: 'Fortunately I haven't needed support from any of the above [formal and informal sources], but thank our PM and team for the constant care and updates'. In contrast, a sample response from a 58-year-old white woman living in Leicester city reads:

I think that the Government needs to have a clear message... They have supported MPs and advisors that broke lockdown rules but preach to us about civic duty. It all feels inequitable and patronising. The [easing] of restrictions feels haphazard and changes are made without a clear plan or guidance.

The continuing of social restrictions on its own, and before local authority concerted intervention, exacerbated existing divisions.

Workplace Restrictions

There was a sense that small business owners had not been given sufficient instruction and support to implement physical distancing guidelines. For some small businesses, implementing guidelines was considered impossible because of lack of space and lack of staff to enforce guidelines. The closure of SMEs was perceived to have disproportionately impacted BAME groups, as they run many of the restaurants and independent stores in the city.

The politicisation of 'sweat shops' as vectors of transmission was a central concern of respondents. Across communities, there was a perception that such issues of exploitative labour have existed for decades, since the closure of the large textile companies. There was a perception that the national media and local authority have picked up on this issue and sensationalised it, pushing the blame back onto the exploited workers themselves. The fact that workers were pushed to such conditions out of desperation and deprivation is overlooked in this national narrative. There was a link made among local respondents between the stigmatisation of sweatshops and multigenerational and overcrowded housing. There was a perception that it was people who work in factories and mills without adequate protection that are coming home to large households.

However, numerous respondents also pointed out that it was not only illegal enterprises but also large factories such as the Samworth Brothers and Walkers who have inadequate conditions of work. There have been a number of outbreaks in local Leicester post-codes that have been linked to these factories. There is a perception that such poor working conditions have existed before the lockdown, though the informalized practices of labour hiring and the tendency to cut the number of workers on the shop floor. There is a perception from trade union representatives that their ability to inspect these conditions is also inadequate due to budget cuts to worker's rights services and union bodies and employment laws that favour employers. The social restrictions brought class and ethnic divides to the fore especially as initial national Government communications has sown a seed of discord.

Shielding and Household Types

There were two different ways in which people spoke about the role of multigenerational households in transmission. First, there was a strong narrative that conditions of overcrowding in households, and particularly multigenerational or multi-resident households, had contributed to transmission. There was speculation that such overcrowding occurred in particular parts of Leicester city, where residents live in terraced housing. It was considered by informants that this narrative was a proxy for speaking about BAME groups; but also a proxy for a classist discourse against low-income and migrant groups that contributed to the stigma surrounding them.

Second, there was a strong narrative across BAME communities about how multigenerational households are important cultural care networks, and sites of shielding for the elderly and vulnerable. In such households, though elderly and vulnerable people were unable to shield the structure was important to provide them with the care and information they needed. In households where elderly and vulnerable people live alone, there was a contrasting strain on kin and neighbours to provide care across large geographic distances. Though it would have been 'easier' to shield if they were alone, the benefit of living in a multigenerational household was the practical, informational and emotional support they needed. Within this narrative, there was a sense that the blame should be

instead apportioned to young people rather than the household structure, and particularly young men, who have been engaging with others and coming back to their homes with elderly grandparents.

By contrast, in some households where elderly and vulnerable people live alone, the inability to access their usual support services had put significant strain on their family members, including children, to provide informal care across large distances. There were instances where family members have needed to move in with elderly and vulnerable people in order to provide this care during the lockdown, foregoing employment and other responsibilities. There was little access to respite care and social support for carers. There were concerns that when more workplaces resume face-to-face interactions these forms of care will be withdrawn and will not be able to be replaced by formal services.

Leicestershire Counties

There was a sense that there was a deepening social divide between Leicester city, which was seen as ethnically diverse and primarily Labour voting; and Leicestershire counties, which were seen as White-British and primarily Tory voting. Respondents from Leicestershire counties who had been released from lockdown reported that their perception of Leicester city was fraught. Though there have been few outward displays of blame in interpersonal interactions, the spreading of hateful and stigmatising media on platforms such as Twitter, Whatsapp and Facebook resulted in some stigma against those from the city. There were challenges in thinking about who was allowed to come in and out of wards that are not locked down if they live in Leicester and work in this ward. There was speculation about where the clusters were, and which ethnic groups were living in these places. Respondents from the counties feared that if the case count in their areas increased, they would be subject again to national intervention. There was also a perceived stigma in the counties against Roma, Gypsy and Traveller communities.

The county's seven boroughs have also experienced the same austerity-related budget cuts at local authority level as the city. The loss of public transport subsidies have been keenly felt during the easing of lockdown, leaving residents isolated. The aging population in the counties meant a lot of people were shielding, and considered themselves vulnerable. Most people have reportedly observed social distancing guidelines, particularly if there were people in their houses who have health issues.

Financially, the impact on aging communities was not perceived as severe, given most are retired and have access to pension schemes. However, those who are self-employed were slipping through the cracks, if this isn't their main source of income they're unable to access income support. The mental health impact on people in the counties had been severe for some due to geographic isolation. During the pandemic, the closure of pubs and other public spaces like the post office had caused residents to feel very isolated. There was also significant anxiety in this population about the loosening of restrictions, and reluctance to resume social interaction. Local small businesses such as supermarkets have been instrumental in providing services to isolated residents. There have been strong structures of volunteer support organised in many communities by local community centres, counsellors and university students.

BAME Groups

There was a strong perception in Leicester City that BAME groups have been disproportionately affected by the virus, which results in both stigma against BAME groups in general; and has deepened social divides. It was suggested that this has been propelled by Government inquiries, national and local media coverage and the spreading of misinformation on social media. All respondents perceived that social restrictions applied to particular post-codes in Leicester, which have a high proportion of BAME residents, was stigmatising to those groups. The use of particular kinds of maps and statistical figures have contributed to this stigma.

There were a number of highly divisive narratives of Covid-19 transmission among all groups. These included the Black Lives Matter protests, Leicester garment factories, multi-generational households, sporting events held by young people, 'secret' prayer meetings in multiple faith groups, and Eid festivities. There was a perception that the informal 'underground' economy has been 'open' throughout the lockdown. Though it was acknowledged that this had kept disadvantaged groups in employment, it was perceived that this has been a vector of transmission. This narrative has been stigmatising on both lines of ethnicity and class. By contrast, it was indicated that there was a counter narrative of blame, where the 'unclean' practices of White-British people are cited as vectors of viral transmission.

The Black Lives Matter (BLM) protests were a significant source of blame against BAME groups. Protests were mentioned multiple times by people living both inside and outside the city in the nation-wide survey; and were generally considered by respondents to be potentially problematic for public health. Respondents in the county, however, were more adamant in referring to 'rioting' as a nuisance, rather than a practical challenge to social distancing. A sample response from a white man living in Leicester county: 'We are in an area that has not been badly hit. We don't have stupid idiots rioting / protesting so most people have abided by the rules. We're fortunate that we have a sensible population'. Another white man, 53-years old and living in the county, commented that 'BLM protests will no doubt lead to a 2nd wave due to no social distancing'. In contrast, a 51-year-old white woman living in the city 'attended two BLM demonstrations' and 'found that very stressful as [she] was worried people would be passing on the virus'; still, she believed 'it was very important to attend'. None of those who expressed discomfort or outrage at the protestors identified as BAME.

With relation to communications, there was resistance from BAME respondents to the perception that BAME groups are 'hard to reach'. Consultation with religious/community leaders has been greatly appreciated. However respondents pointed out that leaders do not always represent significant sub-groups in their communities. Therefore mutual aid and NGO groups could also be consulted on more hidden differences of gender, age and point of migration origin. Culturally appropriate content has helped, but did not always fully register very important gender and sub-community differences. For example, the publication of videos for the Muslim community encouraging their communities to stay at home initially involved only male Imams, and did not engage any female community leaders. Linguistically appropriate content has helped, but this is not always related to the realities of language use. For example, English language videos were initially distributed with written translation in a number of languages. However, many people in these groups speak but do not write these languages (Panjabi, Kachchhi etc.) so they cannot read the written translation.

Inter-group Relations

There were a range of intensifying social and political divides between communities in Leicester. Though there was a perception, mainly from White-British respondents, that inter-faith and inter-community relations are respectful and peaceful, this is contrasted to an alternative perception, mainly from South Asian respondents, that such relations were breaking down between groups. This breakdown, it was suggested, preceded the Covid-19 pandemic and Leicester local lockdown but had been intensified by it.

There were deepening social divides on religious, ethnic and class lines - between the Muslim, and Hindu and Sikh communities. Historically, the faith communities had common cultural ground, speaking the same languages and performing the same cultural traditions as many were from the same home countries such as India and East Africa. However, in the successive generations these cultural or linguistic links are not as strong, and faith relations are increasingly tense. Geopolitical tensions between India and Pakistan over Kashmir, the rise of Hindu nationalism, and the Citizenship Act have been cited as contributing to this tension. Recent events in Leicester and surrounding areas such as the implementation of PREVENT, grooming incidents, the Black Lives Matter protests, the

Brexit vote and the 2019 General Election have contributed to these divides. During the pandemic, misinformation and hateful content has been spread by both communities via Whatsapp videos.

Within the Hindu and Sikh communities, there was a classist divide between the middle class Asian communities of established migrants, and working class migrant communities such as the Daman community and those who work in the 'rag trade'. The former cited the latter as vectors of viral transmission as a result of overcrowding in housing and working conditions. There was also a faith-based divide between some of the Sikh community and the Hindu community; where tendencies toward Panjabi separatism and resonances of Sikh oppression in 1984 were remembered in relation to the Citizenship Act that was introduced in early 2020 by the Indian Government.

Within the Muslim community, there was a significant diversity that runs primarily along ethnic lines. Historically, Leicester's Muslim community has been unified in its representation by political bodies. However, this unity is fragmenting as there are a number of sub-traditions who have their own forms of organisation and are very open to interfaith engagements and engagement with Government. These tensions played out with respect to consultation about Covid-19 restrictions. There is a perception that the Muslim community are being 'unhelpfully pulled' in different directions, like a 'political football' and many were not sure where to turn.

There were also rising tensions between the sizeable Muslim community and the small Jewish community in Leicester. These relations were seen through the lens of the Israel-Palestine conflict. There are a number of Palestinian advocacy groups in Leicester that have an international profile. The Local Authority has encouraged these organisations, for instance with the Mayor visiting the Holy Land 6 years ago; and the banning of products from occupied territory 2 years ago. These tensions were refreshed due to the annexation of Palestine by Israel earlier this year.

Community Support Structures

There was a perception that the cuts to funding over the past decade at local level have impacted the ability of grassroots social services to support disadvantaged groups through the lockdown. There was an increasing number of people regularly turning to food banks for meals, and an increased demand for food provision across communities. This need is being met by faith and community groups who are redirecting existing programs, funds and donations. However, it was also speculated that the zealous will to provide services to those who need it may have caused some communities to breach restrictions. Community and faith groups had been making special efforts to reach out to vulnerable service users and congregants regularly to provide psychosocial support and advice. Though the provision of a stipend for those with No Recourse to Public Funds status is well received, there was concern about the situation with asylum seekers who had newly arrived in Leicester from Glasgow as they were isolated and unable to survive on the allocated allowance. Community service providers were looking to provide in-community and outreach support in place of their usual services, particularly to vulnerable groups like parents and children, and were looking to charitable grants to fund such work. There was a perception across community and faith services that there has not been sufficient financial support, as organisations are unable to access small business support.

On the basis of these findings we suggest the following recommendations for communications and community engagement in situations of uncertainty caused by social restrictions and interventions to combat Covid-19.

Our data shows that adherence to social distancing guidelines is dependent on seven important factors (1) people are able to access those guidelines (they are present on a platform and in a medium familiar to the citizen); (2) people are able to understand those guidelines (meaning they are presented clearly, a language they understand); (3) people are able to keep up with those guidelines (they are not changing too regularly); (4) people trust those who make and communicate the guidelines; (5) people see the Government enforcing these guidelines equitably; (6) people

perceive a need for the guidelines; (7) people are able to meet their own needs and the needs of those that they care for while adhering to the guidelines.

Our interlocutors across ALL ethnic, religious, gender and class groups reported issues with these seven factors relating to adherence. This resulted in a sense across communities that their needs or situation has not been visible or accounted for in the response to the pandemic; breaching the social contract between the state and citizens. Such frustrations play out at different levels, perceived as clinical vulnerability, discrimination, stigma, anger and poor mental wellbeing. Ultimately, it resulted in a lack of trust in Government guidelines. This was not just within BAME groups, and there are many common concerns among white post-industrial working class, other white groups such as Eastern Europeans and recent migrant populations. This suggests that both linguistically targeted and more general messaging about, and for, disadvantaged hard to reach groups that share common concerns is necessary along with direct financial and other support to follow social isolation guidelines.

Issues 1, 2, 3, Unclear, inaccessible communications on guidelines

Recommendation: Provide clear, compassionate and culturally sensitive, public communications on social distancing guidelines in multiple languages. Publicise through local community media such as radio and newspapers.

Issue 4: Information is not communicated or filtered through trusted sources.

Some marginalised groups do not trust services to meet their needs, reporting bad experiences with professionals in the past, and hence are unwilling to do what is necessary to access health and social care.

Layers of communication between vulnerable people and various health, financial and social support services have broken down. Some deprived communities are completely alienated from support services such as refugee- or migration-oriented services and some faith-based organisations.

Recommendation: Engage a range of local community and faith-leaders to share strong messages of support and guidelines for social distancing and other policy changes during local lockdowns. But pay attention to potential inequalities within communities, and do not assume that obvious routes can reach all of the most needy groups. Base any community champion programmes or peer support infrastructures on a preceding process of social mapping. This should be participatory with all groups included. Attention needs to be paid to intra-group divisions and to intersections of class, ethnicity and religion.

Issue 5: There is a perception that guidelines have not been enforced equitably, resulting in stigma at community level and anger toward the Government.

Social distancing was perceived to be enforced too severely and unequally on some BAME groups such as young black men; reminiscent of 'stop-and-search' policing.

There was a perception that the Government has allowed exceptions for individuals such as Dominic Cummings, and festivals such as VE Day, that were not provided to others, resulting in social divides and feelings of discrimination.

There was a fear that social divides are widening in regional areas, such as the North East of England, along racial, religious and ethnic lines, where speculations about who is not complying to social distancing guidelines, and harassment reported.

Recommendations: Introduce local processes of consultation, with special effort made to include BAME and youth advisory councils for the enforcement of social distancing guidelines during local lockdowns. Encourage inter-community initiatives that provide an interface between marginalised

communities. Paid community champions and peer educators should come from all groups and across classes so that they could forge connections across social boundaries and generate a new community of cooperation from these collaborations.

Issue 6: There was a split between those who feel that the Government had acted too harshly, and those who felt they have acted irresponsibly. For both groups, they felt that the Government had not provided for their needs.

Consultation with ethnic, religious and community groups has not always been representative of the diverse range of interests and needs within them, producing further disadvantage for some and exacerbating mistrust of Governments.

There have been conflicts between local authority service providers and community service providers, with the former perceived as paternalistic causing mistrust of Government at community level.

Consultation with ethnic, religious and community groups has not always been representative of the diverse range of interests and needs within them, producing further disadvantage for some and exacerbating mistrust of Governments.

For BAME groups, high mortality rates have resulted in high perceptions of risk, particularly for keyworkers. These groups request additional safeguarding measures in their workplaces.

Recommendation: Set up a community liaison scheme at local community level that integrates such groups and community leaders into the structures of local policy-making, workplace safety, inter-agency coordination and communication when local lockdowns are necessary.

Issue 7: Adhering to many of the social distancing guidelines has been impossible for people who can't access basic essentials.

Grassroots community support services, often informal, cultural or faith-based and local, have been critical to supporting isolated families during the lockdown and making possible their adherence to social distancing guidelines by providing much needed food, medication and culturally-specific advice in navigating welfare, health and financial support.

Such grassroots services are often funded voluntarily by their communities and unable to access local authority grants, threatening their long-term sustainability and the possibility that they might be reactivated during local lockdowns.

There is thus a risk that local authorities become dependent on informal care providers to meet the service gap during lockdowns without adequately compensating them.

Some marginalised people do not trust services to meet their needs, reporting bad experiences with professionals in the past, and hence are unwilling to do what is necessary to access health and social care.

Recommendation: Fund local, cultural and faith-based community support groups to deliver necessary services during social interventions. This funding should be provided over the long term.

Conclusion

This section has shown how a lack of scientific knowledge, clear communication and population-level evidence has resulted in processes of stigmatisation and blame as people and policy makers speculate as to the drivers of transmission. In order to combat these processes, it is necessary to build a fuller picture of how the virus is spread and how it is impacting people's lives; how they are responding to guidelines and perceiving risk. The kind of evidence that is needed is rich and nuanced

accounts of social interaction and adherence behaviour. We see our research process as a model for generating such evidence – rapid and broad ethnographic studies that track networks of care and patterns of social behaviour without presupposing stereotypes. This kind of evidence can complement statistical and quantitative data collection at population-level by helping to answer *why* certain groups are behaving the way they are.

Our policy recommendations for building vital social cooperation to deal with the second wave and recovery from it would include:



Short Term Recommendations (including for the second wave):

- Increase the legitimacy of social restrictions by explaining social restrictions through a unified national and local voice; communication through trusted figures about scientific facts especially in online and social media; going beyond known community leaders to hidden sub communities of gender and age; providing a diversity of oral (rather than written) language materials. Government communications and policy should explain the long term rationale for policies and their connection to each other to reduce sequential uncertainty
- More nuanced national and local communications that give clear explanations for transmission in particular environments rather than ‘within communities.’ Emphasise that these environments are a risk and responsibility for ALL social groups
- In addition, these communications should state that when people become unwell with Covid-19, it is because they are members of hardworking families who care for members of their communities. They are taking the risk of keeping the country and communities going and because of this they may become unwell through exposing situations.
- Create policy that relates more closely to peoples’ lives embedded in an ethnographic understanding of the situations of communities and co-production. During co-production attention has to be paid to within ethnic and religious group inequalities as much as to between group inequalities. Any community engagement must actively seek to see the community from different vistas within it before co-producing policy
- Policy, and strategies of community engagement should disaggregate the BAME category. Vulnerability to Covid-19 should be mapped as a series of structural factors that intersect to create disadvantage in each social situation
- When restrictions are applied there should be a related expansion of mental health provision and support along with wider access to individual medical guidance. This could be provided by GPs, paid peer-educators and community champions and mental health charities and professionals
- When local or national restrictions are introduced active long-term financial and practical support must be given to all community groups

Longer Term Policies

- The new community renewal centres should be a space of encounter between different

communities and age-groups and form greater bonds of mutuality across boundaries

- Although these appear to be 'only' local level responses as the current national controversies over Tier 2 restrictions in the North and Midlands show, they are in fact the only basis for building cooperation to overcome Covid-19. There can be no national cooperation unless local authorities, regional organisations and communities are made part of the whole through concerted policies backed up by greater devolved financial resources. As a priority local public health officials, community groups, NGOs, mutual aid organisations and charities must be funded to mount a local response for national recovery



Shukri Adan and some of her volunteers hand out meals and bags filled with small gifts for Eid in Hackney Downs, 2nd August, 2020. To mark the end of fasting for the month of Ramadan there is traditionally presents for the children and a feast that families enjoy together. This year, due to social distancing guidelines, Eid couldn't be celebrated in large groups so Shukri organised meals and presents to be handed out to families one by one in the park.

Grey Hutton/National Geographic Society Covid-19 Emergency Fund



Conclusion: Social Thriving

This report has examined the impact of the Covid-19 pandemic on disadvantaged households and communities across the UK. It has revealed how social restrictions associated with the pandemic have cut off the very networks of carework and kinwork that sustain our society and economy. Without these networks within and between households, people are isolated and unable to meet their physical, financial and social needs. This impact has been felt most acutely in communities and by groups who experienced disadvantage prior to the pandemic such as disabled people, black and minority ethnic groups and low income groups. However, it has also been felt acutely by new kinds of people, rendered vulnerable by these unprecedented events. These groups include care givers, most often women, who are shouldering multiple sets of caring responsibilities; essential workers who are experiencing new forms of stigma; and the elderly who are cut off from those who meet their basic needs. This report has explored the impacts of this situation in four arenas of social life.

- First, the impact on households. Across all groups, there was a sense of frustration at the impracticality and inequality of Government regulations around household interaction. Permeating these responses was a sense that the 'household' bounded by the physical house or flat was not the significant unit for social support, carework or emotional connection.
- Second, the impact on local communities. Access, assessment and adequacy of formal care have all emerged as issues during the first period of national restrictions and remain significant as we enter the second wave. There is increased demand for formal care services such as food banks, mental health services and institutional foster care.
- Third, the impact on livelihoods. The Treasury project is not in touch with the realities of casual work, gig-work, depressed wages, in-work poverty and deprivation that are the widespread status quo in the UK. The result of this dissonance is a range of inequalities, between those who can access Government support and those who cannot, that exacerbate existing long-term forms of economic exclusion and regional deprivation.
- Finally, the impact on society. In situations of uncertainty people attempt to regain agency by following guidelines and assessing risk. Our research shows that Government communications and policies, as a whole, have not reduced uncertainty for the UK public. Instead, because of their variability, inconsistency and remoteness from life, they have intensified it.

This report offers an alternative approach to policy making that accounts for the old and new forms of disadvantage that have been produced by the pandemic. This places the networks of care and kinwork that make up society at the core of policy decision-making. It suggest five key steps for achieving this.

- First, the development of Covid-19 policies that support households, especially the most disadvantaged ones, to weather the second wave and renew themselves. This can be

achieved by social restrictions that better match the way in which people live, and that prioritise the survival of networks such as social bubbling.

- Second, the investment in connected and comprehensive social infrastructures to support communities to adhere to restrictions and recover from their economic and social impact. This involves investing in statutory and non-statutory services; and promoting communication and cohesion at local level. This could be best achieved through the establishment of local renewal centres that link social services, paid community champions and peer supporters, and test and trace functionalities in ways appropriate to the needs of diverse community groups.
- Third, building an economic package that meets the diverse working conditions of the population, including informalised workers. Government should, as a priority, take a centralised approach to regional regeneration through Government investment, particularly in family businesses and SMEs.
- Fourth, cooperation should be achieved by active policies of communication that push back against blame narratives, along with co-production of solutions with local authorities and communities. This co-production should not naively place its hope in the power of 'the' community as a single bloc. Instead it needs to be aware of the inequalities within and across communities that make it difficult to engage with diversity. Stigma, blame and division have been generated that have entrenched these issues. To work with communities we need to build new spaces of encounter, mutuality and engagement across social boundaries. This can best be achieved through a combination of strategies involving community champions, peer educators, primary care and mutual aid groups. These must go beyond a simplistic understanding of the social ecosystem by building a local map of situational inequalities faced by specific groups and finding ways to overcome these. We think that this can best be achieved through systematic investment in community renewal centres that would be more ambitious than the older Surestart centres. They would create a shared space of encounter in which different groups could negotiate their relations with each other. It is likely that mutual aid groups that were active in the first wave and national restrictions would need to be revived in order to take ownership of these spaces. We think that the will is there among the UK public in a way that has not yet been tapped into.
- Fifth, all of these measures depend on the collection of more accurate evidence on how people are living and coping through the pandemic on economic, epidemiological, social and psychological indicators.

This report stands as a testament to the power of social listening. We have learnt from all of our interlocutors, and have treated them as experts on their own situations. Ultimately the success of these five policies of supporting households, enabling social infrastructures, building livelihoods, sustaining cooperation and social listening should be measured through a social calculus. This would ask of every policy- how does it contribute to the reduction of inequality and increase in well-being? If we applied such a social calculus, we would be able to renew our relations of care and redirect our financial policies towards a new kind of social thriving.

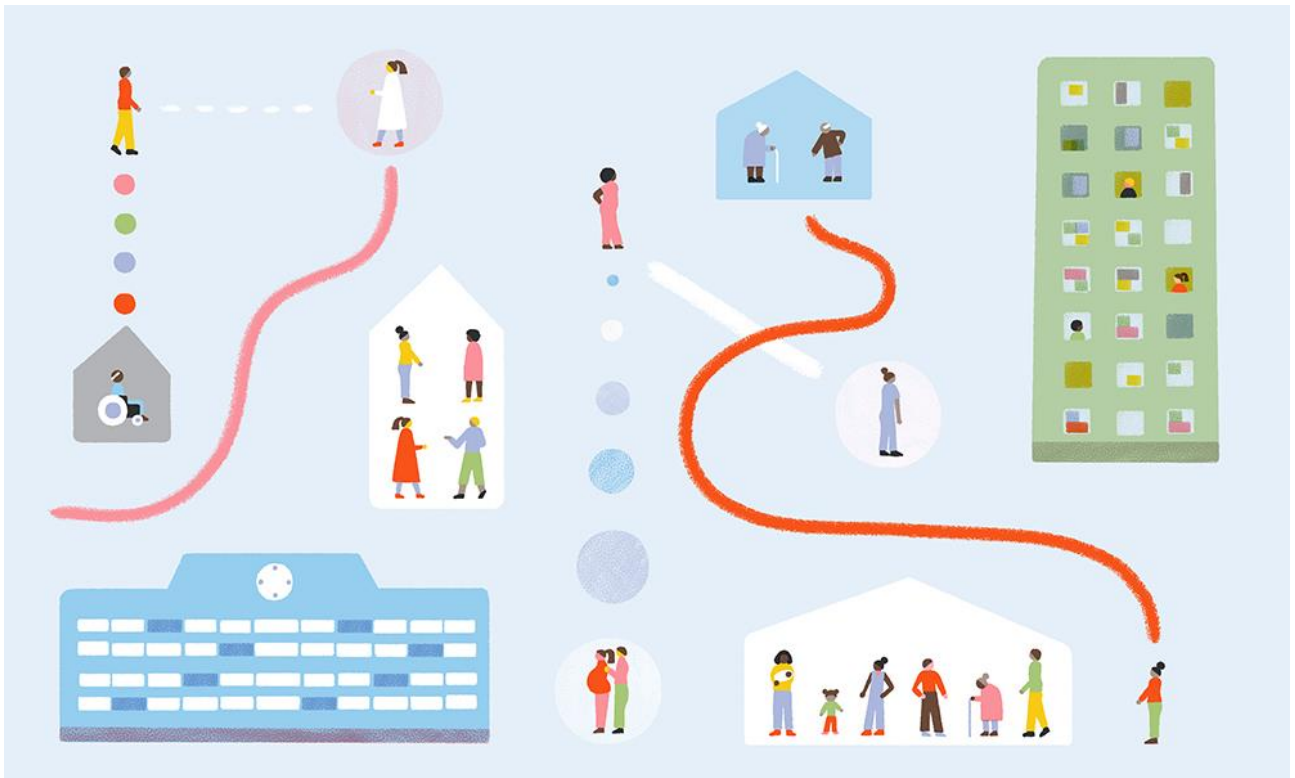


Illustration by Maggie Li

Appendix: Methodology

Interviews with local experts

We conducted semi-structured interviews with ‘local experts’ and mediators who are at the intersection between formalised and informalised varieties of care between March and August 2020. These are people who occupy dense nodes of connection including: volunteers, advice workers, social workers, mutual aid group members, faith or community leaders, homeless charity workers, small shopkeepers. At the same time, those of us with longer term links with disadvantaged communities through fieldwork approached interlocutors. Research participants were selected through the existing networks of the research team, and particularly through deep existing engagements with communities across the UK. Participants were contacted via telephone, Whatsapp or ZOOM. Research participants were asked for consent to be part of this study and assured that data would be anonymised and would not be shared beyond the research team. Interviews followed agreed themes set collectively by the research team, and directed by Laura Bear. In some cases, interviews were recorded. Interviews were transcribed and summarised.

Though interviews were conducted across the UK with a range of interlocutors, representative of a broad cross section of communities, we also conducted focused research in particular geographic regions and on particular topics. Smaller teams conducted a range of interviews and surveys with community members in two geographic locations – Leicestershire (where we also conducted a survey, by Nikita Simpson and Nicholas Long) and East London boroughs (conducted by Connor Watt and Jordan Vieira). A third case study was conducted by Dora-Olivia Vicol on employment advice through the Work Rights Centre. Perspectives across these communities were contrasted, and interpolated with ONS and local public health data, and deeper historical evidence, to produce *case studies*. Individual or paired researchers conducted thematic investigations pertaining to subjects of interest or expertise, to produce *spotlights*. These themes include homelessness (Johannes Lenhard), early-years providers (Farhan Samanani), small business (Fenella Cannell), multi-generational households (Jaskiran Bhogal), motherhood, pregnancy and fertility (Anishka Gheewala Lohiya and Caroline Bazambanza) and debt (Deborah James).

Survey

In mid-June, the team led by Nicholas Long conducted a survey of 3,800 residents across the UK. Respondents answered questions regarding their experience of the pandemic and lockdown using both numerical rankings and longer free responses. The data collected ranged from household composition to shielding practices to Government social support, illustrating the various constellations of care arising within lockdown conditions. Researchers employed both qualitative and quantitative methods to analyse the dataset, and visualise holistic models of personal experiences and relationships in interaction with Government guidelines and restrictions on social contact. Findings were used to substantiate and add breadth to the ethnographic studies and spotlights comprising the body of the report. The survey, rather than providing the foundation for the teams’ case studies, was used retroactively to provide context for the regionally-specific insights of interviewees and to gain general insights about national discourse and trends in public opinion. Survey analysis was conducted by one researcher, Milena Weurth, with support from Nikita

Simpson, using Microsoft Excel. Survey analysis was selectively incorporated into the different sections of the report as it pertained to the subject matter.

Analysis and Co-Writing

The research group collaboratively conducted a thematic analysis of the qualitative and quantitative data. During the data collection period, the group met weekly to discuss themes emerging from interviews. When data collected concluded, the team met for a structured workshops, hosted on ZOOM and facilitated by one researcher, Nikita Simpson. This workshop was focused on emergent themes. In preparation for this workshops, each researcher read the transcripts of one of their peers and noted emergent themes. During this workshop, researchers separated into break-out rooms to discuss relevant insights from their interviews and from the transcripts they had read. The outcome of this workshop was the four themes that structure this report. One researcher, Nikita Simpson, then produced a draft report summarising all evidence under these themes, that was read by all researchers. Subsequently, the researchers organised themselves into four co-writing groups who each met for a structured session facilitated by Laura Bear and Nikita Simpson. The groups included The groups included (1) Domestic, Anishka Gheewala Lohiya, Jaskiran Bhogal, Rebecca Bowers, Caroline Bazambanza; (2) Care deficit, Connor Watt, Jordan Vieira, Farhan Samanani; (3) Economic productivity, Catherine Whittle, Alice Pearson, Dora-Olivia Vicol, Deborah James. (4) Uncertainty, Stigma, Blame, Laura Bear, Nikita Simpson. The groups re-drafted each theme, triangulated evidence with other secondary sources and produced policy recommendations. The four themes were then compiled to produce a cohesive report by Laura Bear and Nikita Simpson, who wrote the introduction, conclusion and executive summaries.

Media

Illustrations are by Maggie Li. Photographs are by Grey Hutton with support from the National Geographic Covid-19 Emergency Fund.

Declarations

Laura Bear is a member of the SAGE SPI-B committee, the Independent SAGE committee and the BAME SAGE sub-group. Nikita Simpson also works as a freelance social researcher for the UK Government's Policy Lab.

Ethics

Approval for this study was given by the London School of Economics Research Ethics Committee [REC ref. 1137].

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