Barriers to Accessing Information

2021

Contents

Introduction

Diversity Matters North West Ltd (DMNW), is a local charity based in the heart of Hyde, working across Tameside with diverse communities. We are a user led, award winning, independent charity working to combat health inequalities, social exclusion and to promote community cohesion. Our key expertise and specialism are our 14-year track record of successful reach and engagement with the local minority ethnic communities in all aspects of our work.

Tameside is one of the 20% most deprived districts in England where 20% (8,800) of children live in low-income families. Life expectancy for both men and women is lower than the England average We know that 13.4% of Tameside residents live in income-deprived households (ONS, 2011).

Our work during the COVID 19 pandemic, shone a spotlight on the ever-widening inequalities and inequitable access to services specifically for those who did not have English as their first language and those who were digitally excluded. Working with key partners across the sectors, DMNW worked tirelessly to ensure local voices were heard and that services were inclusive of the people they are there to serve. Soon after evidence started to emerge where a Runneymede finding on the impact of COVID19 on different ethnic minority groups, reported in October 2020 on how the lockdown measures had disproportionately affected some communities more than others. “Those from Bangladeshi and Black African communities were more likely to have experienced financial insecurity or mental health issues than their White counterparts”.

The Equality Act 2010 requires that public authorities must have due regard to the need to eliminate discrimination, harassment, and victimisation. Tameside Metropolitan Borough Council (TMBC) invited DMNW to help and assist with understanding this further to aid future delivery of services. Therefore, to gain a better understanding of the barriers facing residents in accessing information particularly in relation to language and in context of the impact of Covid-19, we embarked on conducting community research utilising our connections and links into the minority communities of Tameside. The consultation was designed to capture peoples lived experience, identify the barriers before and during covid-19.

Methodology

In collaboration with TMBC, we developed a questionnaire consisting of both open and closed questions and then transferred this onto Microsoft Forms to capture the results and to track diversity of responses. This in turn helped us to identify age groups and communities we need to focus and reach out to.

Bearing in mind the high levels of positive COVID cases in Tameside, our approach was carefully planned out where we were able to keep both staff and residents as safe as possible. Undoubtedly this meant that our engagement would be limited by this additional challenge, and we needed to think ‘outside the box’ to ensure we were able to reach out to people as much as possible.

The methods we adopted was to operate remotely and / or face to face where it was safe to do so. We took a place-based approach where, rather than expecting people come to us, we took the questionnaire to people via organised outreach stalls, attending sessions and groups across Tameside, where participants were already engaging.

Our approach adopted various engagement methods ensuring the questionnaire was accessible and where required, we would provide language support via bilingual staff, volunteers and paid interpreters to enable people to complete the questionnaire, fully informed. This included:

- One to one semi structured informal interviews conducted over the phone and face to face (when safe to do so or on zoom) to existing DMNW service users
- Circulating the questionnaire link via WhatsApp broadcast groups with bilingual voice messages, specifically in Bangla.
- Circulating link on DMNW social media platforms
- Outdoor market stall outreach was organised to reach wider audience and target groups, specifically those that are not engaged with DMNW.
- Indoor venue outreach stalls were organised in areas where minority communities are already accessing / present / visiting. This included local primary schools, cash and carry's, local community groups
- Focus groups: face to face and online via Zoom
- Engaging with community leaders and local faith centres
- Identified and targeted hubs where target groups would engage in, leaving questionnaires for lead volunteer or group leader to complete with their service users.
- Hard copies of the questionnaire were made available with pre-paid envelopes, these were left at key organisations for people to access / pick up across Hyde and Ashton.
- Emailing questionnaire link to volunteers and partners via DMNW, Action Together, GM Equality Alliance CRM and newsletters.
- Attending Network Events to capture wider feedback such as the PEN networks.

The questionnaire was conducted over a period of 4 months, spanning across Tameside and targeted specifically, but not exclusively, ethnic minority groups.

Findings

175 residents successfully completed the questionnaire. Out of this, 37 people completed it online, the rest were done on hard copies with assisted support, these were then transferred onto Microsoft Forms. 34% of males engaged with the questionnaire compared to 65% female. We have frequently found this to be the case with our previous DMNW community consultation research and within our own activity programmes. We also found that 66% of the reported they were married, 10% were widowed, 16% were single and people who were divorced made up 4%.

135 people did complete response for age. Not surprising that the age groups engaged on the questionnaire generally reflected the users of our own services. This was essentially due to our targeted work and that the older generations were prone to face additional barriers to access relating to lack of language and digital skills than the younger generations. We knew from previous conversations within these communities, the main challenges faced by people from the minority ethnic groups were predominately for the older age ranges.

Volunteers and Interpreters

We recruited and inducted 3 bilingual volunteers who supported the research, gathering the information via telephone, supporting outreach and with data input. We found that, on average, when volunteers conducted the telephone and outreach stall questionnaires in a different language, each questionnaire took approximately 30minutes to an hour to complete.

Our paid interpreters reported taking 1 hour to complete 3 questionnaires.

Working with Community Groups and organisations

To reach as many people as possible, led staff member contacted and / or visited 17 groups, organisations, and businesses, holding over 34 conversations and or meetings face to face and over the phone. The group leaders ensured their service users participated and helped to complete some questionnaires, which eliminated some challenges around language.

Groups engaged with	No. of contacts made
Diversity Matters North West Ltd	3
KhushAmdid	3
Deepak Drishti	3
Shree Bharatiya Mandal, Indian Association Tameside	2
Infinity Initiative	3
Hyde Bangladeshi Welfare Association	2
West African Development	3
Hyde Jamia Masjid	2
Hamza Masjid	2
Ashton Central Masjid	1
Hattersley African Group	2
Local Primary School	2
Hyde Past and Present Facebook group	2
Hyde Bloom Facebook Group (Gee Cross)	2
Cash and Carry: (Ahmed Brothers, Sylhet store and Al-Amin Food store)	3

We successfully managed to organise 2 workshops with local community groups, one in Hyde at DMNW and one in Ashton with Deepak Drishti.

The workshops were facilitated in English, Bengali and Urdu. This enabled us to break down initial barriers, build trust, increase confidence and encourage two-way dialogue. Participants talked openly about what, how and why the barriers affected them in

accessing services both pre and during the pandemic. Many expressed that it was a extremely frightening time for everyone. They also stated that it was frustrating at a time where they needed to access services more than they ever had to but found that they couldn't. People found it difficult in getting essential things like needing to book an appointment with G.P, requesting repeat prescription, especially those who lived alone or did not have English as their first language.

"I had to stay home as the government guideline said I couldn't request for my medication from the GP because I couldn't provide my address or date of over the phone even.

"I had to ring people, but they couldn't help because they had to get permission from me because of lockdown nobody could go to each other house (GDPR) eventually it was sorted out by local councillor, who could speak in my language, she registered me on the council for food hub".

Many spoke about their concerns about:

a) Financial struggles because of people losing their jobs, this had a negative impact on their life and mental wellbeing. People couldn't apply for universal credit even after they let HMRC know that they stopped working. This was due to a lack of English language and having a lack of digital skills. This meant people had their benefits stopped. People continued to pay mortgage / rent by borrowing from family and friends or some ended up in huge debt.
b) Lack of trust in government: People didn't go for Covid test at the first lockdown because they were fearful if they tested positive, they would have to isolate and those members of their family that could work would not be able to. They were scared because most of the earners of the families were either taxi drivers, self-employed or were a part of the catering business. Support services that were available was inaccessible.
c) Accessing essential services: When people were isolating, they couldn't access food banks or hubs, it was a scary time for many, often feeling alone and forgotten about, that their lives, their health did not matter. The food banks that were open did not provide culturally sensitive or appropriate, healthy food, this further prevented people from an Islamic faith, to access food banks. In addition, there existed a cultural stigma around accessing food banks and the fear of being seen to access a food bank. The participants of the workshops and people we spoke to people over the phone, all mentioned that there was a lack of cultural awareness. There was a general assumption that people had to fit in with services without the help and support they need to do so. If you didn't engage then you didn't need the service. The survey showed that most people found it difficult or very difficult to access information because either lack of digital skill or language barriers.
d) The workshop also highlighted the impact on their child's education, the expectation for parents whose did not have English as their first language to home school their child put them at a further disadvantage and contributed to increased anxiety and poorer mental health. These families often tended to be lower income families. Coupled with the struggle of providing healthy or any food for their families, the situation only worsened for some.

Ethnic Diversity

40% of the questionnaire participants were from a Bangladeshi heritage, 14% identified as Indian, 13% Black African, 12% Pakistani, 12% White British, 3% Polish and 6% were from various other backgrounds including, Nigerian, Kashmiri, Arab, Afghani, Irish and mixed race and 1% not applicable. This reflects DMNW strong relationship and connection within the South Asian communities of Tameside.

Religion

The highlighted that most of the participants who completed the questionnaire were Muslims, with 56% participant rate, Christians (including The Church of England, Protestant, Catholic and other denominations), with 16%. This was closely followed by Hindus, with a 14% participant rate. Buddhist, Jewish, Sikh, Orthodox, Spiritualist; all have 1 % participant rate each. People with no religion, who took the quiz were 6%. People who prefer not to say make up the remaining 1%. The big difference between some of the results are due to the questionnaire being targeted mainly at the Ethnic Minority Community.

Language

Interestingly, the survey highlighted that in Ashton the most common language spoken by people from Black African heritage was Portuguese whereas in Hattersley, Yoruba was most used language within this ethnic group.

The largest language spoken within people we questionnaire was Bengali, second largest was English, as their first language. This was particularly interesting for us, when we dug deeper into the questionnaire results, we found that this was mainly because other members of the family completed the questionnaire on behalf of their elderly parents, family members, whose first language was not English.

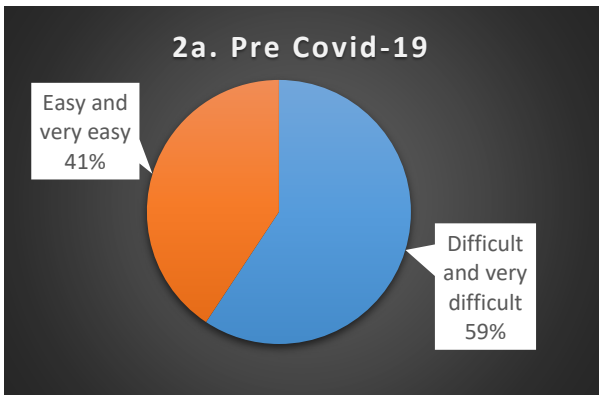
Location

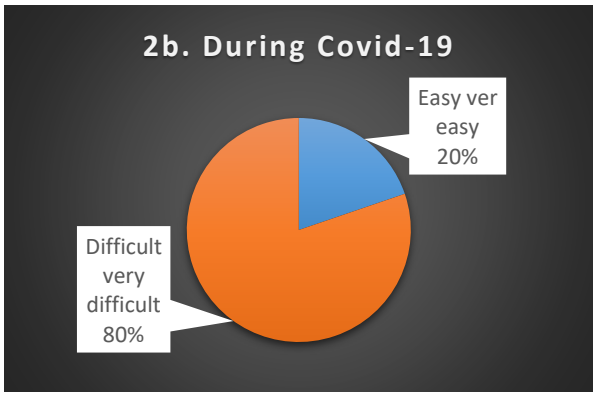
Our survey told us that most people who completed the questionnaire resided in Hyde (42%). 27% of people were from Ashton, 14% from Stalybridge and 14% from Dukinfield. These high %'s were due to targeted work, identifying hotspot areas where we were able to reach and engage minority ethnic communities and where we focused our main outreach interventions. Rest of the people that completed the questionnaire were from Denton, Audenshaw, Droylsden, Mossley, Hattersley, Manchester, Chorley, Sale, Bolton and Stockport.

Demonstrating reach wider than the targeted areas.

Ease of Accessing Information and Services

One of the questions we asked people was how they found accessing information and key service pre and during COVID19, so that we could understand the depths of the challenges they faced.





Pie chart 2a shows that 59% of the participants found it difficult to access information pre lockdown: even with the help of family, friends and relatives. At that point, despite knowing about services, people living outside of Ashton said accessing services face to face was difficult even then, as no local services were available, travel was required and at the point of accessing a service, no language support was available or very difficult to get. The older people, the first-generation migrants are likely to not have English as a first language compared to second or third generation children of migrants who may be bi-lingual or have English as their first language. Some of the comments were:

"Gujrati language support or services are not available".

"I always needed help from family and friends, without them I cannot access the help I need"

Pie chart 2b. shows a dramatic increase to 80%, where 115 people told us that they found it more 'difficult' and 'very difficult' to access information or services during Covid-19. This was particularly because of the language barrier, lack of digital skills and having no face-to-face services as most of the services and community centres shut down leaving people unaware of where to go and ask for help. In contrast to pre pandemic, many of those who would normally rely on friends and extended family members to help with accessing services, found themselves even more isolated as they could not get this support when they needed this the most, as the government lockdown restrictions put an end to interactions with others during the pandemic. It is important to note that some respondents did not answer this question. Some of the comments we received were:

"it was very hard to access information because of language barriers and lack of digital skills"

"Very difficult because I couldn't do online doctors' consultation and upload photos because I didn't know how to"

"It isn't just covid time it's also before then. It's hard when people don't translate into other language – how am I able to get the help I need so my family don't suffer, that my children don't suffer?"

Caring for someone

vast majority of people said they did not care for anyone (83%). In the Bangladeshi, Pakistani and Indian community most people don't see looking after an elderly member, or a relative with long term illness, physical disability or end of life care as a "caring responsibility", culturally, this is more of a duty. People told us that the cultural stigma around declaring the caring responsibilities is damaging for many families in these communities, therefore, they refrain away from seeking the help and support they need, ultimately worsening their own health. Some people spoke to us about how some parents within these communities' struggle with accepting their young child is in need of educational support, thinking this will re-enforce the concept, that their child will be singled out and ultimately affect their future.

Main barriers to accessing information

We asked people what the main barriers were to accessing information, people selected more than one answer.

Barriers in accessing information		**%**	**Quote**
1	Digital skills	18%	"couldn't access the internet" "being everything online made it very difficult for me."
2	Written English / reading	17%	"I couldn't do online information and fill in the form"
3	Covid related restriction	16%	"Because my children live far away and I live on my own". "I don't know who to ask for information" "Very hard to actually speak to someone to get help". "It was so bad that the bereavement team didn't have any contact number to reach them on". "I had to make a complaint to get this raised and it still wasn't satisfactory".
4	Verbal English / Language	15%	"Very difficult to access information via phone such as GP appointments" "I have very limited knowledge of what's going on. I can't speak English or understand"
5	Lack of access to digital device	10%	"Difficult doing online because no digital device" My children live faraway; I am still learning to use my mobile phone. I live myself I don't know who to ask for any information".

6	I do not know what to do to access information	10%	"I didn't know where to look or go on website to look for Covid related information".
7	Lack of access to internet, e.g., no Wifi,or broadband at home, limited data on smartphone etc.	10%	"Difficult doing online because no digital device I don't have mobile phone and much help".
8	Lack of available family or friends who can help and/or support me	8%	"Family lives faraway".
9	Unhelpful or non-co-operative staff	6%	"Very hard to actually speak to someone to get help. It was so bad that the bereavement team didn't have any contact number to reach them on. I had to make a complaint to get this raised and it still wasn't satisfactory. I did however manage to speak to someone who helped me eventually. This was the last thing that I needed when my son had died".

The top three main barriers came out as:

1. **Lack of digital skills**
   Digital skills including lack of access to digital device and internet came as the top barrier, nearly 50% of people we surveyed! The data shows and reflects that people have lack of digital skills within the Ethnic Minority. During Covid-19. As most services were online this made it difficult to Access Services Especially G.P, hospital appointments and having Covid - 19 test or registering for vaccinations. Tameside Councils Digital Inclusion Report highlighted that women, disabled people, people from Bangladeshi, White, or Pakistani ethnic backgrounds, and people who are economically inactive are all more likely than other groups to be digitally excluded". In recent years, digital exclusion across ethnic groups has varied considerably, for example, in 2011 31.4% of Bangladeshi adults were estimated to be non-internet users, whereas in 2019 that figure had reduced to 11.7%. The report also highlighted that digital exclusion was closely linked to income where "only 51% of households earning between £6,000-£10,000 have home internet access, compared to 99% of households earning over £40,001".

2. **Written language barrier / reading and verbal**
   Lack of digital skills was closely followed by lack of language skills including reading, written and verbal. It had been difficult for the Ethnic minority communities to access information and overcome the language barrier. During Covid -19 lockdown people were not able to get the support they usually would get from family members, relatives, friends, and local community centres. Few elderly members found it difficult to ring the G. P's,

pharmacies for repeat prescription because couldn't speak English, some managed to say their address or date of birth. Although some people could speak English, they still struggled to access support information because of their inability to read effectively to navigate through the mass information and complex use of English language. This made it difficult to access information and key services when they needed it the most.

3. **Covid related restrictions**
   People found it difficult to access services due to the lockdown restriction. Vulnerable elderly members who lived on their own found it difficult to register for the food bank and getting medication delivered to their house. This was because they were already depending on their family members, friend and relative because of the language and lack of digital skills pre pandemic. With the social distancing guidelines in place, family and friends could not help!

It is important to also highlight that 57 people just did not know where or how to get the information they needed during the pandemic. A shocking 49 people we surveyed also said that the lack of available family or friends who could help and/or support them were inaccessible due to the social distancing government guidelines.

Communication

We took this opportunity to ask a question around what the best way is to reach and communicate with people in the future, so we do not make the same mistake twice and that we learn and grow, ensuring we listen to voices of people to shape future approaches and strategies.

The data indicated that 82 participants wanted to receive information through translated leaflets in their own language.

The second largest group of people wanted to receive information through text and SMS messaging as this was easy to receive and keep on their phones. This was mainly those could read messages and use their mobile handsets.

These were the most common answers which suggests that these methods of contact are the best form of relaying information for future purposes. It is extremely important that all forms of information when given to the minority ethnic communities is translated into one's own language so that they can fully understand information given, therefore, be able to make better informed decisions and choices that will affect their lives and that those of their families. It would also help in circumstances such as lockdown or if the person doesn't have any family. In some situations, people cannot read nor write in their own language so for these specific people a more interactive approach should be taken for example videos or voice messages explaining information and use of images in the communication tools.

Limitations and Challenges

The research did not come without its limitations and challenges. The process started at a time where we faced triple barriers of school holidays, religious festivals and navigating through the government guidelines on social distancing.

The addition of the challenges brought on by the pandemic restricted our engagement which meant that alternative engagement methods needed to be adopted to ensure we reach and engage a wide perspective of residents in Tameside. Some of the limitations and challenges we encountered were:

- Completion of questionnaire: Where the people completing the questionnaire identified as younger, this was as they were completing the form on behalf of another person so a true account of the individual demographics could not be obtained. We also saw some questions not being completed – this meant we could not get consistent data. Those that we supported on a one-to-one level completed all sections. We found that more women completed the questionnaire than men, given more time we would have targeted this groups specifically to ensure a fair representation. It was also apparent that we did not engage anyone who had an additional ability, whether people caring for that individual completed on behalf of them, we do not know. Given more time and resources we could have explored this better.
- Outreach: Engaging with people during the outreach in the marketplace was particularly challenging as people were hesitant to speak. The nation had just come out of lockdown, and they were cautious about 'close' contact meetings.
- Face to face community sessions / groups: Many of the community sessions, workshops, face to face events had been postponed due to COVID19. When they restarted there was a backlog of booked guest speakers, therefore opportunity for us to attend these groups to conduct the consultation was limited. Despite all the hurdles DMNW has managed to complete 175 questionnaires.
- Translations: we resorted to seek support from our bilingual volunteers and paid interpreters to help capture feedback and engagement from different ethnic groups, where language was a key barrier to participation. This meant further coordination and planning was required to ensure safety of all those who participated.
- Time Consuming: The questionnaire itself had 25 questions and within this, multiple choice and open questions requiring free text. Interpreting the questionnaire to residents on a one-to-one basis was time consuming which meant that to complete one questionnaire would take double the time, ultimately, we could not reach as many people as we would have liked.
- Volunteers: were hesitant to engage such early on after lockdown restrictions were lifted. We had to conduct risk assessments for all our sessions where volunteers came into contact with staff or local people to ensure their safety was paramount. We found that commitment levels were up and down, so a lot of our work was also directed towards keeping motivation, ensuring safety and maintaining regular communication.

Conclusion

Given the challenges brought on by the pandemic combined with the limited time spent on the survey, we successfully engaged 175 people. This was only possible due to a) the pre-existing relationships and links within the communities, people, and organisations b) the help and support of our bilingual volunteers and c) enlisting support from interpreters to ensure we are able to reach out to as many people from different backgrounds as possible. We know that people's health was further

aggravated by the pandemic and that minority communities were disproportionately affected.

1. Accessing information: More than 75% of participants could not access information and even the 25% who did have to have help from others to do so. This has always been an issue pre Covid-19, the language barrier (verbal or written) or lack of digital skills. Prior to COVID people were able to get support face to face with their GP, hospital, offices, community services and family or friends. But during Covid-19 this has been very difficult because of restriction- support was mostly online or over the phone. People had difficulty in applying for benefits, and elderly members couldn't register for food banks. When bereavements occurred, the problems were worse:

"Very hard to actually speak to someone to get help. It was so bad that the bereavement team didn't have any contact number to reach them on. I had to make a complaint to get this raised and it still wasn't satisfactory. I did manage to speak to someone who helped me eventually. This was the last thing that I needed when my son had died."

2. Lack of Digital Skills: We know that the impact of digital exclusion has been highlighted by the rapid shift towards digital services during Covid-19. Those that faced digital exclusion struggled with accessing services. Digital exclusion is also linked to income, therefore, by having access to better employment opportunities should help to alleviate some of the digital poverty experienced by many during the pandemic.

   During the lockdown peoples' lack of knowledge in digital skills was brought to the forefront where many people found themselves at a disadvantage. The lockdown further restricted people from learning how to use technology properly. This was a big issue for the minority ethnic community. Lack of digital skills closely correlated with people not being able to read and speak English. The people who struggled with this felt as if they couldn't do anything on their own and constantly needed the help of others. Some examples of this problem were that people were not able the make GP appointments, not be able to access the internet and registering for vaccination.

3. Language: written / verbal: The language barrier was a very wide- spread issue that many were finding difficult to overcome, being in lockdown didn't help this either. People weren't able to fill documents online nor written forms to the best of their ability simply because they didn't understand what it was asking or saying. All communications were in English, so those that did not understand English, could not read English, just did not get the crucial information they needed to keep themselves safe and access health services at a time when they needed it those most.

4. COVID19: Many people said there was insufficient amount of information translated into languages people could understand. This led to a lack of knowledge in COVID related issues. The situation became more difficult because there was no one to one contact and most services went online. During Covid -19, people were more scared and needing the support from services. A

government report into the disparities in the risk and outcomes of COVID19 identified that people of Bangladeshi ethnicity had around twice the risk of death than people of White British ethnicity". Many of those who would normally rely on friends and extended family members to help with accessing services, found themselves even more isolated during the pandemic, as they could not get the support when they needed it the most, as the government lockdown restrictions put an end to interactions with other people. Minority communities found themselves on their own, sacred, isolated, and alone. When trying to access health services, many women were forced to be consulted by a male GP, due to their inability to request a female GP, compromising their religious belief and their own identity. More than often, the actual ailment goes undiagnosed and any underlying health issues missed. This raises the issue of cultural awareness, whether more investment is required to educate frontline staff.

Recommendations:

1. **Improve digital accessibility**
   with increasing number of statutory services now going online as a bid to cut costs, we are seeing seldom heard communities further isolated from society, resulting in increased poor mental and physical health. By investing in local, culturally sensitive, accessible support to help skill up people from diverse ethnic groups, where language is a key barrier to engagement and accessing information and services, we could be saving lives and giving people a better quality of life, therefore, increase life expectancy amongst vulnerable groups.

2. **Improve accessibility of translation and language support**
   Language has been a barrier pre-pandemic, only exacerbated by the pandemic, highlighting the widening inequalities and equitable access to services. Reliance on family and friends providing language support is short sighted and does not address the issue at the core. By ensuring key services are inclusive to the communities they serve will ensure greater access by seldom heard and minority communities, enabling independence and a better quality of life. One size approach does not fit all, therefore due consideration need to be given to targeted support and intervention to allow of true justice in our systems. This could be having interpreters available at the time of access, investing in widening the diversity of a workforce and or providing cultural awareness training.

3. **Develop more inclusive and / or tailored communication methods**
   To effectively engage and reach out to seldom heard communities where language is a barrier, translated messages is key whichever median of communication is adopted. People told us on this survey that bilingual videos, voices messages, visual graphics (less text), leaflets had worked the best but also, that phone call to check upon them during such a scary time in their lives was crucial for them feeling better both mentally and physically. We knew that when we started on the community consultation that we would need to think "outside the box' to how we can reach as many people as possible, removing barriers and using as many resources as possible at our disposal. Ensuring

this was factored in at the onset meant that people had as much opportunity as everyone else to complete the questionnaire and get their voices heard.

4. **Services need to be culturally sensitive and aware as to the barriers that people face when trying to access services**
   Many of the group conversations within the workshops and when we spoke to people over the phone mentioned that there was a lack of cultural awareness. There was a general assumption that people had to fit in with services without the help and support they need to do so. If you didn't engage then you didn't need the service. Having a cultural awareness of the communities we serve, will enable us to empathise and understand peoples need better, by adopting simple changes in our communication will enable greater engagement and improved wellbeing as people start to feel listened to, valued and not feel discriminated at the point of accessing a service.

5. **Public services need to develop and improve links with community organisations supporting those communities and individuals who are seldom heard and may struggle to access information**
   Taking a co-produced approach to involving peoples voices from the earliest opportunity is key, therefore, allowing for more opportunities to enable this to take place is crucial to ensuring we do not repeat the same mistakes twice. This often achieved via support through the voluntary sector due their unique community-based position. However, in order to achieve this, the sector requires further long-term investments to improve the stability of the services they deliver and to continue to reach and engage those that statutory services fail to reach.

Appendices

Appendix 1: Community Consultation Questionnaire

Barriers to Accessing Information: Questionnaire

As a key member of Tameside and Glossop Inequalities Reference Group, Diversity Matters North West has been invited to take a lead on the '**Barriers to accessing information e.g. language**' work stream – with a focus on hearing and understanding the barriers facing our communities to access information. This is particularly in relation to language, and in the context of the impact of Covid-19.

Is this something you are interested to input into?

- If no, say thank you for your time.
- If yes, do you have 20mins to go through this questionnaire?

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1. What is your Ethnicity? Please put 'x' in one box below.

Bangladeshi	
Black African	
British White	
Indian	
Pakistani	
Polish	
Other (Please state):	

2. What is your first language? Please put 'x' in one box below.

Bengali	
Urdu	
Punjabi	
Gujrati	
Hindi	
Swahili	
Polish	
English	
Other (Please state):	

3. What is your Postcode?

_____

4. Which Town do you live in? Please put 'x' in one box below.

Ashton	
Denton	
Hyde	
Stalybridge	
Audenshaw	
Droylsden	
Mossley	
Dukinfield	
Longdendale	
Other	

5. In general, how easy or difficult did you find it to access information and services **before** the Covid-19 pandemic began in early 2020? *Please put 'x' in one box below.*

Very easy	
Easy	
Difficult	
Very difficult	

6. Please provide more information on the option you have selected in question five

_____
_____
_____
_____

7. In general, how easy or difficult did you find it to access information and services **since** the Covid-19 pandemic began in early 2020? *Please put 'x' in one box below.*

Very easy	
Easy	
Difficult	
Very difficult	

8. Please provide more information on the option you have selected in question seven:

_____
_____
_____
_____

9. What are the main barriers you or your family face when trying to access information and services? *Please put 'x' in as many options as apply and provide more information below.*

Barrier	Put X in box below
Written language barriers	
Verbal language barriers	
Lack of access to digital devices, e.g., computer, laptop, tablet, smartphone	
Lack of access to internet, e.g., no Wifi or broadband at home, limited data on smartphone etc.	
Lack of digital skills	
Unhelpful or non-co-operative staff	
I do not know what to do to access information or services	
Physical disability	
Cognitive disability, e.g., dyslexia, attention deficit disorder, autism, etc.	
Lack of available family or friends who can help and/or support me	
Bureaucracy and "red-tape", e.g. being passed from service to service without being able to access the information and services needed	
Covid-19 related restrictions	
Lack of capacity or staff resource at the services I am trying to access	
Other	

10. Please provide more information on the option you have selected in question nine:

_____
_____
_____
_____

11. Were you able to access all the information you needed during the pandemic? *Please put 'x' in one box below.*

Yes	
No	

12. Please provide more information here on the option you have selected in question eleven:

_____
_____
_____
_____

13. Thinking about the future, what do you think is the best way for organisations to get the information to you?
(Please tick "x" preferred method)

Websites		Social media	
Printed (leaflets or flyers or newsletters)		Radio	
Email (e.g. email newsletters)		Information videos (such as on You Tube, Tik Tok or hosted on organisational websites)	
Phone calls		Billboards & advertising hoardings	
In person (include public meetings and events)		Text/SMS messaging on mobiles	
Video call(zoom, skype, MS Teams)		Other	
Letter			

14. Would you like us to contact you with updates on research and report findings related to Barriers to Accessing Information?
If so, please provide your preferred method of contact details below. Please note, by providing your contact details below you are providing consent for Diversity Matters North West and Tameside Metropolitan Borough Council to contact you with updates regarding research and updates related to Barriers to Accessing Information.

*We will not share any information you provide with anyone else including third party organisations You can request that your details are removed at any time by contacting (**info@diversitymattersnw.org.uk and pen@tameside.org.uk**).*

a) Email	
b) Phone Call	
c) WhatsApp	
d) Text messages	

15. Please provide your name and phone number or email address below:

ABOUT YOU

We would like to ask some questions about you. This information will help establish whether there are any particular issues or themes between protected characteristic groups and barriers to accessing information and services. The information you provide will be kept entirely confidential, will be used for statistical and research purposes only, and stored securely. If there are any questions you do not wish to answer, please move on to the next question.

16. Are you: (Please tick one box only)

❑ Female
❑ Male
❑ Other (Please state below)
❑ Prefer not to say

17. Is your gender identity the same as the sex you were assigned at birth?

❑ Yes
❑ No
❑ Prefer not to say

18. What is your age? (Please state)

19. What is your religion or belief? (Please tick one box only)

❑ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
❑ Buddhist
❑ Jewish
❑ Sikh
❑ Hindu
❑ Muslim
❑ No religion
❑ Any other religion (please specify)

20. What is your sexual orientation? (Please tick one box only)

❑ Heterosexual / straight
❑ Gay or lesbian
❑ Bisexual
❑ Prefer not to say
❑ Prefer to self-describe
❑ Other sexual orientation (Please state below)

21. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age. (Please tick one box only)

❑ Yes, limited a lot
❑ Yes, limited a little
❑ No

22. Do you look after, or give any help or support to family members, friends, neighbours or others because of either, long-term physical or mental ill-health / disability or problems due to old age? (Please tick one box only)

❑ No
❑ Yes, 1-19 hours a week
❑ Yes, 20-49 hours a week
❑ Yes, 50 or more a week

23. What is your marital status? (Please tick one box only)

❑ Single
❑ Married
❑ Civil Partnership
❑ Divorced
❑ Widowed
❑ Prefer not to say

24a. Are you pregnant, on maternity leave or returning from maternity leave?

❑ Yes
❑ No
❑ Prefer not to say
❑ Not applicable

24b. If yes, are you:

❑ Pregnant
❑ On maternity leave
❑ Returning from maternity leave