THE INSTITUTE FOR CONNECTED COMMUNITIES

University of East London

NEWHAM COUNCIL WELFARE CHECK-IN CALL PILOT

Learning from a rapid evaluation 2021–2022

RESEARCHTHATMATTERS

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1. Executive summary

This qualitative study explores from the research participants' subjective perception the effectiveness of the piloted Welfare Check-in calls, which aims to help residents living with COVID-19 to better self-isolate. The pilot ran from March 2021 to November 2022 in the London Borough of Newham. Specifically, the problems that Newham Council expected to address in this piloted programme were the lack of adherence to isolation, lack of information about common exposures and contacts, residents being unable to isolate due to lack of support, and residents becoming unwell at home without appropriate medical help. This study investigated how deprived communities, at risk and vulnerable groups are engaged in the service; engagement themes where good reach is identified; learning where good reach is not identified; and the perceived benefits and impacts of the services, including service users' assessment of the quality of the intervention and increased trust in the Council. Using semi-structured telephone interviews – in combination with held data - we have collected and thematically analysed the oral accounts of 41 adults who used the service between May and November 2021.

What is borne out in this study is that the piloted intervention has been effective in reaching and helping most, if not all, of the research participants to better self-isolate after testing positive for COVID-19. It has provided research participants with an unsolicited, compassionate and responsive service, which has often been able to leverage support/resources to meet most of the research participant's physical, emotional and social wellbeing needs to better self-isolate.

It has undoubtedly been a challenge and pressure for research participants to cope during their self-isolating period. What matters most to research participants has been finding solutions to the adverse effects of self-isolating, such as loneliness, anxiety and boredom, as well as struggling with the physical effects of COVID-19, such as high temperatures, weakness or numb senses, and needing assistance with daily practicalities, such as groceries, chores and childcare. Evidence suggests that research participants adhered to government guidance (see UK Government, 2022), and started self-isolating as soon as symptoms were first recognised and received a vetted COVID-19 test soon afterwards. For this reason, access to, and engagement with, the Welfare Check-in calls has reportedly made self-isolating easier due to receiving inbound calls, feeling that they have a sense of control over the frequency and volume of calls received, and when the help has been focused on building-up family resilience.

Undeniably, information sharing was viewed by many of the research participants as problematic. Given that the responsibility to identify his/her own set of needs has been placed on the research participant, information about the services/resources on offer could have been shared better, and enhanced still further, by providing printed

material in different languages to help in the process. Research participants would also have liked to have experienced less-scripted encounters with call handlers and welcomed more questioning of their home situation to jointly identify what service/resources was utmost needed.

In doing so, research participants stress that they could have more effectively engaged in the supportive conversations if they were given more information about the services/resources open to them. Consequently, research participants reported withholding information because of a lack of knowledge about the scope of the call. These matters underline how research participants have gone on to conceptualise and talk about the 'quality' of the intervention and how the Council earned their trust. Nonetheless, access to the Welfare Check-in call has reportedly been of benefit for the bulk of research participants. Research participants have appreciated the care and support provided to them in the calls, and many of the participants who did not request additional help still found the supportive conversation of immense value in overcoming feelings of loneliness and low-levels of depression.

The research participants have identified numerous areas in which the supportive conversation could have been improved. As stated, research participants felt that written information about the provision would have helped them to make the right choices, at the right time. Research participants recommend that call handlers should try and gather more insight into household size and circumstances. Despite taking part in a call, some research participants report on their inability to listen and absorb the oral information shared with them. Unbeknown to call handlers, a minority of research participants also felt somewhat pressured by their family members, faith and culture to not accept external help. This should not be confused with intimidation, but it is driven by a need to protect loved ones and prevent family separation. Other research participants' put their inability to engage in a supportive conversation down to a combination of factors such as COVID-19 symptoms, home working, caring responsibilities and having English as a second language.

To summarise, research participants would have liked to have experienced a less scripted and more empathic discussion/conversation, which would enable them to open more and allow the call handler to explore their living situation and needs in much more depth. Despite these imperfections in the piloted programme, the research participants' trust in the Council was nudged forward. It is also important to note the relatively small size of the sample group, where recall bias has likely occurred. Firstly, due to the ability of some research participants to accurately recall events surrounding the call due to COVID-19 symptoms, and secondly, being engaged citizens holding positive viewpoint of the Council. In the sampling strategy, we also attempted to recruit a representative number of 18-19 years who were reached by the pilot programme - mindful of the youthfulness of the Borough – however we were unsuccessful to reconnect with sufficient numbers mainly due to disconnected mobile phone numbers.

2. Introduction

In September 2021, the Institute for Connected Communities based at the University of East London was appointed by Newham Council to undertake an independent evaluation of the Welfare Check-in call offer. This report presents the findings from the evaluation, based on Welfare Check-in calls carried out between May and November 2021. In this introductory section, we give an overview of the project background and how it was structured, and we explain the evaluation aims and methods. We then go on to explain the structure for the remainder of the report.

This study has gathered evidence from the research participants about their subjective meaning and understanding attributed to their exposure to the supportive conversations through the Welfare Check-in calls intended to help self-isolating at home. The study reveals the background and context of the supportive conversations, detailing why some research participants put themselves last, behind loved ones, managing family poverty, the challenges when advocating for other family members, communication and cognitive reasoning, emotional support, needs-led support, political awareness, trust and quality of attitudes towards the Council communication and presence.

Newham is a deprived and ethnically diverse Borough. Fewer than 5% of the Borough lower super output areas are in IMD deciles higher than the median decile; 73% of the population are of Black, Asian or ethnic minority background. Populations which are mobile, marginalised, and poor in both time and money experience disproportionality of access to, and uptake of, a range of health improvement programmes, including screening and immunisation. **Public Health England monitoring data for Newham and London show a consistent failure to achieve WHO and national targets of uptake and coverage for routine childhood vaccinations such as MMR and meningitis ACWY**. Additionally, low uptake of seasonal flu vaccine for older adults with long-term conditions has been documented, especially among Black (African/African Caribbean/Mixed race) populations in Newham. Local attitudes towards vaccination take-up can be used as a proxy for trust in scientific knowledge, political agents and agencies.

During the past 20 months, the public health team in Newham have been working with partners via the Well Newham community partnership to address inequalities and develop programmes with champions, the voluntary, community and faith sector (VCFS), and NHS partners to address the health issues which are associated with these inequalities.

It was anticipated that many of the population will experience significant barriers to vaccine uptake, ranging from the structural (non-registration with GP, distance to vaccine site) to the cognitive (fear as hesitancy – fears of experimentation or side effects, language in which information is presented, fear of repercussions of engagement with statutory agencies, and loss of employment) and social (membership of misinformation-sharing networks). Addressing these barriers was also an approach to which the Council was committed as part of Well Newham, and the 50 steps to healthier borough programme, the 2020–2023 Newham health and wellbeing board strategy.

Therefore, this evaluation considers the effectiveness of Welfare Check calls in the London Borough of Newham. **The Newham Welfare Check call is delivered by the COVID-19 Response Team (CRT), and provides residents with COVID-related advice, support and benefits. It is a solution-focused service piloted by the Council to help residents who have tested positive to better self-isolate, by using a resident-centred approach, with prominent emphasis placed upon supportive conversations.** To paraphrase the Skills for Care organisation, the 'supportive conversation' approach should be led by what is important to the person, but the COVID Response Team member can also prompt and shape the discussion. Therefore, the call requires enough time and resources. The resident may need time to feel confident and comfortable to participate, but getting it right means that residents are offered the advice, help and benefits they want. Focused on what matters to them, rather than what the call handler think is most important. **The evaluation is aware of the unpredictable immediacy to the emotional burden of COVID, and the influence of the emotions on interpreting the value of the service, and also inappropriate moral judgements by practitioners – the blurring of outputs and outcomes**. Therefore, a crucial part of the research process has been disentangling the research participants' lived experience of the intervention from the commissioners' perceptions of planning and delivering the pilot.

2.1 Background and context

The problems that Newham Council expected to address in this piloted programme were the lack of adherence to isolation, lack of information about common exposures and contacts, residents being unable to isolate due to lack of support, and residents becoming unwell at home without appropriate medical help (see Eraso and Hills, 2021).

Aims:

- to have supportive conversations with residents, providing advice and linking them to support to isolate

- to build trust with residents, and better foundations for future engagement, demonstrating that local authorities have the residents' best interests at heart
- to increase compliance with isolation, and to prevent onward transmission of COVID-19.

The project plan was developed in February/March 2020 for a single team of officers who, through supportive conversations using an integrated ICT system, carried out, as required:

- Welfare Checks (including some new processes, such as backward tracing)
- contact tracing
- shielding calls
- Hotel Isolation offer
- vaccination bookings.

The following work streams were set up to deliver the pilot:

- recruitment, training (e.g. safeguarding, GDPR) and equipment (computers, headsets etc.)
- technology and data integration (including case management system)
- scripts, referrals processes (e.g. to NFA) and standard operating procedures
- finance and budgeting
- monitoring and evaluation (including development of reporting dashboard).

From December 2020, health and welfare checks were delivered to residents aged 60+ who had tested positive for COVID-19. From February 2021, health and welfare checks were delivered to *all* residents who had tested positive for COVID-19. Support offers had been set up during the first wave – befriending, Newham Food Alliance etc.

3. Methodology

The overall goals of the evaluation were to:

- assess the feasibility, effectiveness and acceptability of the COVID-19 Welfare Checks
- identify implementation factors from the residents' perspectives that might affect the continuity, and to enhance services across the Borough
- determine the levels of trust between the local authority and residents, where trust is defined as holding a "positive perception" about the actions of Newham Council
- build understanding into residents' ability to self-isolate as a result of supportive Welfare Check-in calls

- To assess the level of transmission of COVID-19 as a result of the isolation programme within those households.

The research questions we explored were:

- how deprived communities, at risk and vulnerable groups are engaged in the service
- engagement themes where good reach is identified
- learning where good reach is not identified
- perceived benefits and impacts of the services, including service users' assessment of the quality of the intervention

3.1 Study design

This study focuses on the London Borough of Newham, and **it uses a qualitative approach to build meaning and understanding into the experiences, insights and thoughts of residents who have used the Welfare Check-in calls, and how they have supported them self-isolating.** Specifically, the study uses narrative research to delve deep into the stories of supportive conversations from the subjective perceptions of the research participants. The study is overseen by Newham Council Public Health Team, and the Department of Health and Social Care Research Team responsible for measuring the Test, Trace and Isolate system in the Borough. The overall goals of the evaluation framework have been to:

- assess the feasibility, effectiveness and acceptability of the COVID-19 Welfare Checks and Hotel Isolation programme
- identify implementation factors from the residents' perspectives that might affect the continuity, and to enhance services across the Borough
- determine the levels of trust between the local authority and residents, where trust is defined as holding a "positive perception" about the actions of Newham Council
- build understanding into residents' ability to self-isolate as a result of a supportive Welfare Check
- reduce the level of transmission of COVID-19 as a result of the isolation programme within those households.

Newham Council expected to see a lower community transmission rate, as well as likely increase in trust in the Council following exposure to the Welfare Check call.

3.2 Qualitative methods

Semi-structured telephone interviews were conducted between November and December 2021. A screening spreadsheet was completed at the time of booking, with basic demographics, whether tested positive, type of service accessed, time period and confirmed usage of the Welfare Check calls. A convenient time and date

were than agreed with the potential research participant to be called back for an interview. All research participants booked for an interview were sent a text message reminder the day before their interview. **Interviews lasted between 30 and 60 minutes, and followed a semi-structured interview schedule, which had several closed but mostly open questions; 39 interviews were conducted in English, one in Urdu/Hindi and one with Cantonese interpretation by the interviewee's daughter.** The interviews themselves were of a relatively informal style, thematic to capture the timeline leading up to the start of testing positive for COVID and following the end of the Welfare Check-in calls. The assumption was that data generated via this interaction would form the insights and empirical evidence for this study. **All the responses were captured by Dictaphone**, and on the researchers' Excel spreadsheet containing the semi-structured interview schedule (see appendix 3)**.**

3.3 Participants

A total of **41 research participants were interviewed**, from a sample pool of residents who used the Welfare Check calls service. The research participants were adult males and females, **aged 20 to 75+, from Black, Asian and ethnic minority groups and White British, from across the Borough, and UK nationals and non-nationals.** Of the 1,282 who were consented to take part in the study by the Council, 571 were eligible for screening calls. The 41 interviewed participants were clustered around seven postcode areas within the Borough, and represented the general demographic characteristics and proportions of Newham. **All the research participants who took part in the study had tested positive for COVID-19**. The names and details of the potential research participants were shared following permission being given by the potential participant to the gatekeeper. At the time of their interviews, all the research participants had recovered from COVID-19. The names, postcodes, dates of birth, ethnicities and contact details (mobile, landline and email) for most potential research participants were obtained from the gatekeeper. All the research participants were given a unique identification code once data analysis had started, to help partially anonymise and protect their identities. All of the research participants' details contained in the report have been fully anonymised.

3.4 Sampling

The study used a convenience and theoretical sampling frame to select potential research participants. We used a convenience sample strategy (e.g. non-probability sampling) drawing on the Council's Welfare Check contact list to identify and screen potential research participants. **In order to avoid gaps in user experience/knowledge, the convenience sampling was combined with a theoretical sampling frame in order to select a representative sample of residents who had been contacted by the service.** Categories such as **age, gender, ethnicity, COVID-19 positive status and postcode** were used to select and invite potential research participants to the study.

A database with 1,282 Welfare Check service users' contact details was received, along with their basic demographics and postcodes. After removing 61 duplicate entries, the number was 1,221, which included 41 sets of households (same surname and postcode) with 2 to 5 family members. After removing children age 0 years to 17 years and research participants with missing age/DOB, the total number aged 18–84 years (born between February 1937 and October 2003) was 965. There were 571 residents with a contact number. After removing residents who refused to share their basic demographic information, or whose ethnicity information was missing, the number was 346. Two postcodes were outside Newham. **A sample of 135 was selected, representing the demographic characteristics and proportions of service users from the seven Newham postcode areas**. Research participants were recruited from the following postcode areas.

Table 1. Research participants' postcodes

Postcode	Total no.	Sample no.	Interviewed
E6	77	30	11
E7	55	20	5
E12	48	20	6
E13	53	20	5
E15	53	20	5
E16	49	20	7
E20	10	5	2
Total	**345**	**135**	**41**

* See Appendix 1 for a profile of postcode E12, which constitutes a comparative case for a typical resident living in the Borough.

Table 2. Recruitment and screening process

Recurrent and interviewing steps	No.
Number of participants called (up to 3 times)	87
Phone number not working	7
Messages left	21
Number called back	2
Number not answering	13
Number refused = 2 (1 stressed out with studies, 1 had a bereavement)	2
Appointments booked	60
Number DNA	19
Rebooked	9
Interviews with language support	2
Interviews with family support	3

Response rate	47.1%

3.5 Data collection

Data collection consisted of **semi-structured telephone interviews**. Screening started in the **week commencing 22 November 2021**, and calls were made at varying times of the day, and days of the week, to increase the chance of contacting potential research participants. Interviews were offered at times and days according to the research participants' needs and availability. This helped the team to complete 41 interviews in less than three weeks. Interviews were conducted by two female and three male researchers between 23 November and 11 December 2021; 11 interviews were conducted over the weekend (9 on a Saturday and 2 on a Sunday); 6 interviews were conducted after 5:00 p.m. on weekdays; 3 participants completed their interviews after DNA 1 to 3 appointments. Three mobile numbers belonged to family members: a resident's wife and a resident's son who had been tested positive themselves decided to give the interview themselves, while one participant's son said he would investigate fully by speaking to someone at Newham before getting back.

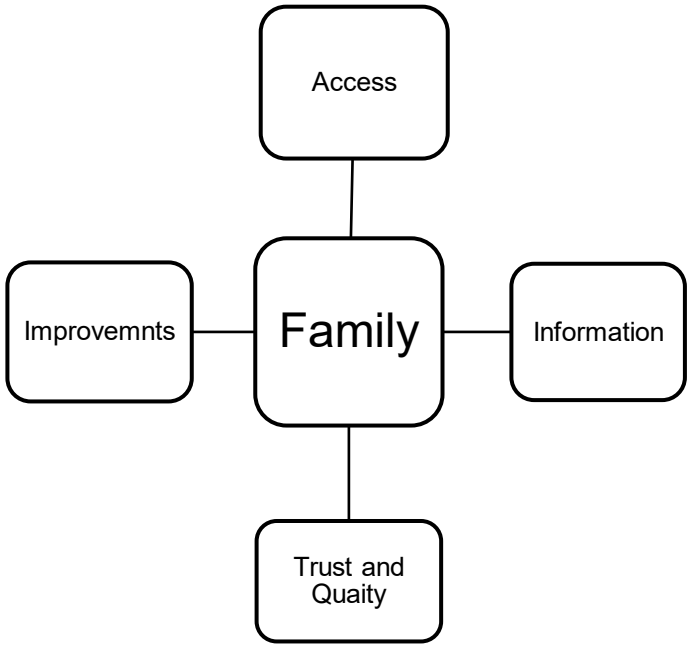
3.6 Data analysis

Interviewers used an **interview schedule comprised of open, closed and a few scaled questions** (see appendix 3). Data generated were inductively coded using the thematic analysis (Aronson, 1995), looking for evidence pointing to patterns and meaning attributed to the supportive conversation, and, finally, descriptive and inferential statistics were used to analyse the administrative data supplied by the COVID Response Team. The qualitative data analysis provides an interpretation of the oral accounts gathered in the data collection process to build key themes to help explain the effectiveness of the supportive conversations in the Welfare Check calls to help better self-isolating. **The analysis framework consisted of two approaches in using qualitative data. The first stage involved converting the qualitative data into quantifiable categories for analysis.** Variables were grouped and distributed through Microsoft Excel pivot tables into the appropriate formats that allowed for the establishment of patterns running the data that provided insights into trends. The transformation from the qualitative data into quantitative data was conducted by describing in which manner the transcribed conversation answered the various questions, and then standardising the answers to generate quantitative results for all participants. For that purpose, a standardised semi-structured interview schedule was provided to the interviewers. All the interviews were also recorded and transcribed for thematic analysis.

The oral data underwent content analysis to generate themes following the principles advocated by Miles and Huberman (1994). This involved repeated readings of the transcripts to gain familiarity with the content. Coding was used to identify key content relating to the objectives of the evaluation, recurring, similar and contrasting content, and links to the literature. The codes were then collapsed into five central themes. **Due to the rapid nature of the evaluation, and the number of research participants involved in the study, we transformed quantitative data to qualitative data to produce descriptive statistical detail that looked for patterns across the data set for further qualitative analysis.**

The evaluation framework is designed to help us collect evidence and share stories of the background and user experience of users of the Welfare Check-in call to determine its effectiveness. The analytical framework focuses on five key areas, illustrated in Figure 1.

Figure 1. The five key areas of self-isolating



At the centre of the analytical framework are the residents and their families. Research participants' stories of self-isolating build into the five key areas – all of which are supplemented by sub-themes – and reveal a range of user experiences, thoughts and ideas about using and improving the fostered supportive conversation approach (detailed later). The cross-cutting sub-themes include:

- why we put ourselves last, and low-income households
- family advocate
- peer pressure and communication and cognitive reasoning

- when support was not needed; needs-led assessment
- emotional support and service availability; political awareness and attitudes towards the Council
- communication and presence.

To analyse these diverse sources, we triangulated the interview data alongside held data to produce the emerging themes/topics, anonymised case studies and inductive charting to identify patterns of behaviour, attitudes and awareness. In the main, we used ground deductive coding within NVivo to allow themes to emerge from the data as well as manual appraisal and categorization of the interview transcripts in whole research team meetings. Most of the data are present in paraphrased forms, and identifiable features of research participants have been anonymised in this report. Research ethical approval was obtained from the University of East London Research Ethics Committee (no. ETH2122-0059) on 6 December 2021.

4. Findings

4.1. How deprived communities, at risk and vulnerable groups are engaged in the service

Insights into families and households

From the research participants' subjective perceptions, the central themes/topics we explore are why we put ourselves last and low-income households. A total of 41 research participants from the above database were interviewed. The average profile of the participants according to Table 3 was aged 20 to 25 and a naturalised British citizen. Out of the 12 research participants aged 20 to 27, seven five were Black females and two were Black males, three were Asian and two were White Other. The demographics pertaining to these research participants can be seen in Table 3. The studies typical research participants reflect the national picture of new COVID benefit claimants (Edmiston et al., 2020)

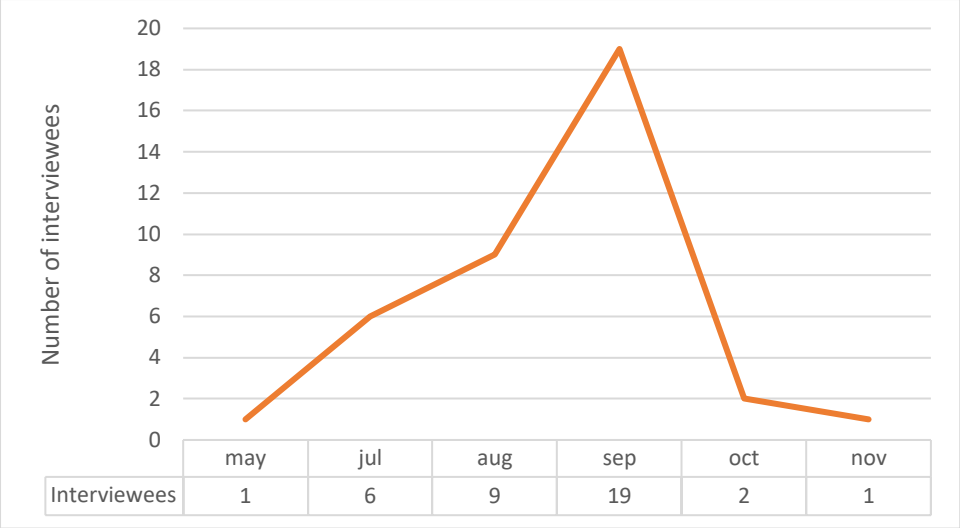
Table 3. Demographics of the interviewed participants

		Freq	%
Gender			
	Female	20	49%
	Male	21	51%
Age			
	20-25	12	29%
	26-30	3	7%
	31-35	1	2%
	36-40	8	20%

		41-45	3	7%
		46-50	5	12%
		51-55	1	2%
		56-60	1	2%
		61-65	2	5%
		65-70	2	5%
		71-75	1	2%
		>75	1	2%
Ethnicity				
	Asian		16	39%
		Asian or Asian British – Bangladeshi	5	12%
		Asian or Asian British – Chinese	1	2%
		Asian or Asian British – Indian	4	10%
		Asian or Asian British – Pakistani	3	7%
		Asian or Asian British – Sri Lankan	2	5%
	Black		14	34%
		Black or Black British – African	7	17%
		Black or Black British – Any other background	1	2%
		Black or Black British – Caribbean	6	15%
	Mixed		1	2%
	White		11	27%
		White British	2	5%
		White other	9	22%
Citizenship				
	British		28	68%
		British citizen by birth	13	32%
		British citizen by naturalisation	15	37%
	Other		13	32%
		EU Settlement	4	10%
		Indefinite leave to remain	9	22%
Total			41	100%

These research participants were asked several questions related to their supportive conversations, and other circumstances related to the service provided by the Council. Amongst the first questions, research participants were asked about the period or time frame in which they had used the COVID Welfare support service. Figure 2 shows the number of research participants per month according to these answers. As can be observed, the number of research participants grows throughout the summer, peaking around September, to drop over the following months.

Figure 2. Research participants per month



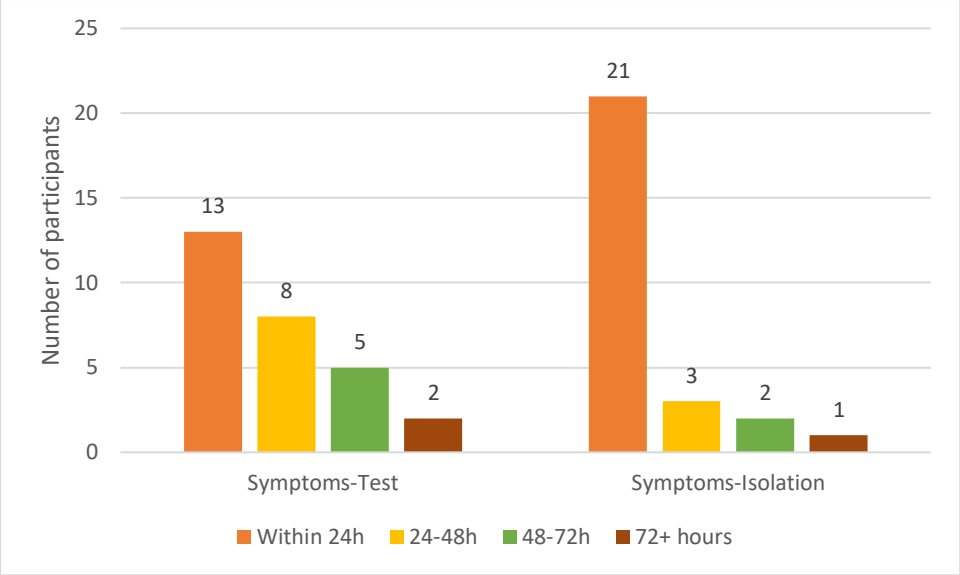
*Note: the first Welfare Check call per research participant

Out of the 41 research participants, 35 participants lived with their families: 20 (49%) participants lived with parents, siblings and other extended family, while 15 (37%) participants lived with wife, husband, sons, daughters and other extended family. Five (12%) research participants lived alone, and 1 (2%) individual lived in a shared property.

Of the 41 research participants, 24 (59%) participants were tested at a testing centre; 11 (27%) participants had a test kit sent to their home address; 5 (12%) participants were tested at a hospital (Figure 4). Out of the 41 research participants, 33 (81%) participants received guidance from the NHS Test and Protect Contact Tracer. Three participants, representing 7% of the sample, received guidance through the Newham Council Service, and 5 (12%) participants left, receiving guidance through alternative means, such as the internet, or could not recall any guidance being received.

According to accounts of the 41 research participants, research participants were more likely to start isolating within 24 hours than they were to get tested in the same time period. In other words, most research participants started to self-isolate – adhering to government guidance at the time – before being tested for COVID-19 (Figure 3).

Figure 3. Time difference between first symptoms and testing, and first symptoms and self-isolation



*The Symptoms-Test variable is composed of 28 research participants, with 13 research participants that did not provide an answer being excluded, while the Symptoms-Isolation variable is composed of 27 research participants, with 14 research participants that did not provide an answer or did not isolate being excluded.

In Figure 3, a comparison can be observed between the amount of time the 41 research participants took between first recognising symptoms and testing, and the amount of time taken between first recognising symptoms and starting isolation. The graph suggests that most research participants started self-isolating within 24 hours, with the number of research participants that self-isolate decreasing starkly as time goes on, while testing, if still concentrated within the first 24 hours, decreases much more slowly, suggesting that people might delay more their testing than they would their self-isolation.

Table 4. Interviewee post-Welfare calls community transmission rates

Household tested positive within 10 days	Frequency
Household member tested positive before or at the same time as interviewee	12
No	18
Yes	11
Total general	41

Out of 41 research participants, 11 participants reported members of their households to have tested positive in the 10 days after they had tested positive, which represents 27% of households testing positive.

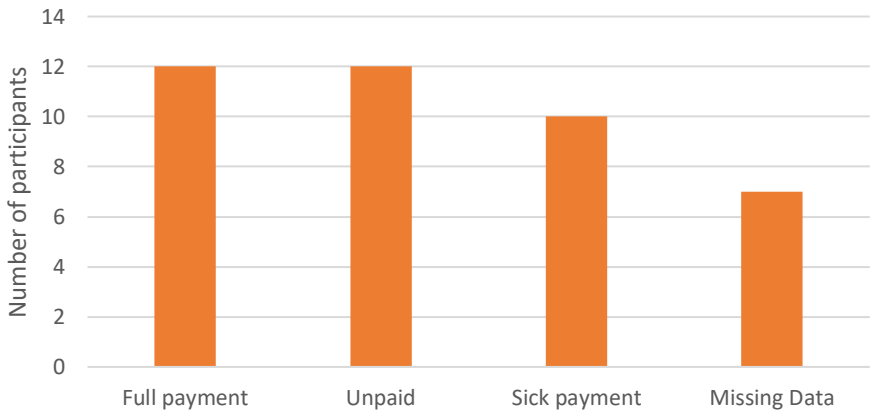
Of the 41 research participants, 11 (27%) participants reported that they struggled with the effects of isolation (loneliness, anxiety, boredom and other feelings of

alienation); 6 (15%) participants, struggled with the physical symptoms of COVID-19, such as temperature, weakness or numb senses; 4 (10%) participants, struggled with assistance-related issues and required help for groceries, chores or other day-to-day maintenance activities during their self-isolation periods; 3 (7%) participants, reported that they had financial struggles.

Of the participants, 18, representing 44% of the sample, were full-time employees, 6 (15%) participants were part-time employees, while another 6 participants (15%), were self-employed; 4 participants, representing 10% of the sample, were out of work, while 2 (5%) participants were retired, and another 2 (5%) were disabled.

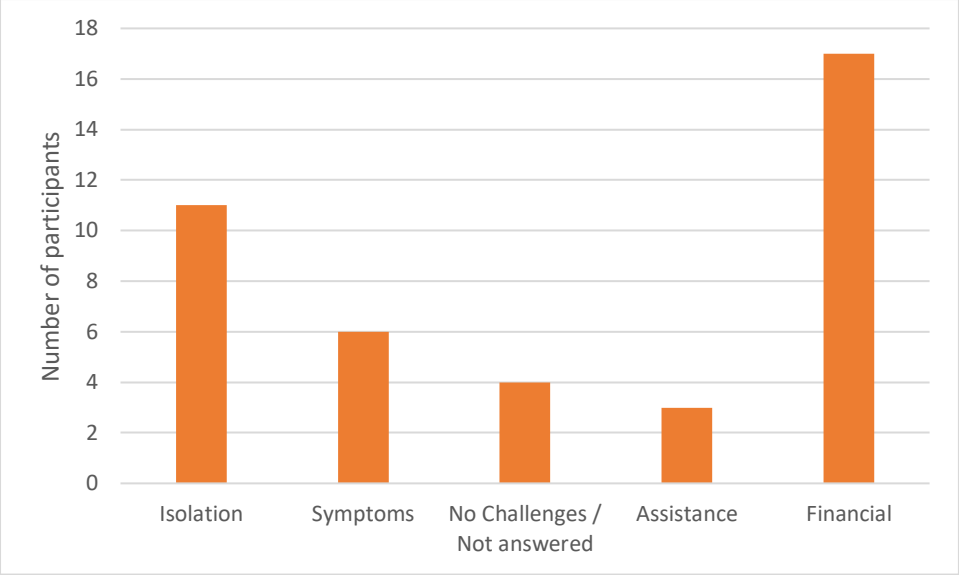
The following section looks at the self-reported income challenges that the research participants experienced during self-isolation.

Figure 4. Income challenges during self-isolation



Of the research participants, 12 (29%) were receiving full payment, while another 12 (29%), were not receiving any payment; 10 (24%) participants were receiving sick payment; 11 participants (27%) had key worker status, while 26 (63%) participants, did not have key worker status. See appendix 2 for a full breakdown of household sources of income during self-isolating.

Figure 5. Main challenges during self-isolation among research participants



Top issues reported during self-isolation by the sample of 41 participants were isolation, where 11 (27%) research participants reported struggling with effects of self-isolation, such as loneliness, anxiety or boredom; symptoms, where 6 (15%) research participants reported struggling with physical effects of COVID-19, such as temperature, weakness or numb senses; and assistance, where 4 (10%) research participants reported struggling with practicalities such as groceries, chores or day-to-day maintenance activities or childcare. Three research participants, representing 7% of the population, reported financial struggles, and 17 (41%) research participants did not report any challenge or did not answer the question.

We now turn to look at the family and/or household make-up and set of circumstances at the time of accessing the Welfare Check-in calls. Research participants were asked questions about the make-up of their household and what challenges they experienced during their self-isolation period at home. The research participants shared two prominent characteristics in their stories of self-isolating. The first common thread is the research participants' strong desire to prevent family separations (e.g. hospitalisation and hotel isolation). The second common thread reported by research participants has been their struggle to make ends meet during the self-isolation period. Research participants have implicitly suggested that their self-isolating experience had been compounded by caring responsibilities and financial hardship, which has often shaped and influenced their reaction to, and decisions made whilst having, a supportive conversation. By descending order of importance, the tables below illustrate what family/household issues mattered most to research participants before having a supportive conversation.

Table 5. Why we put ourselves last

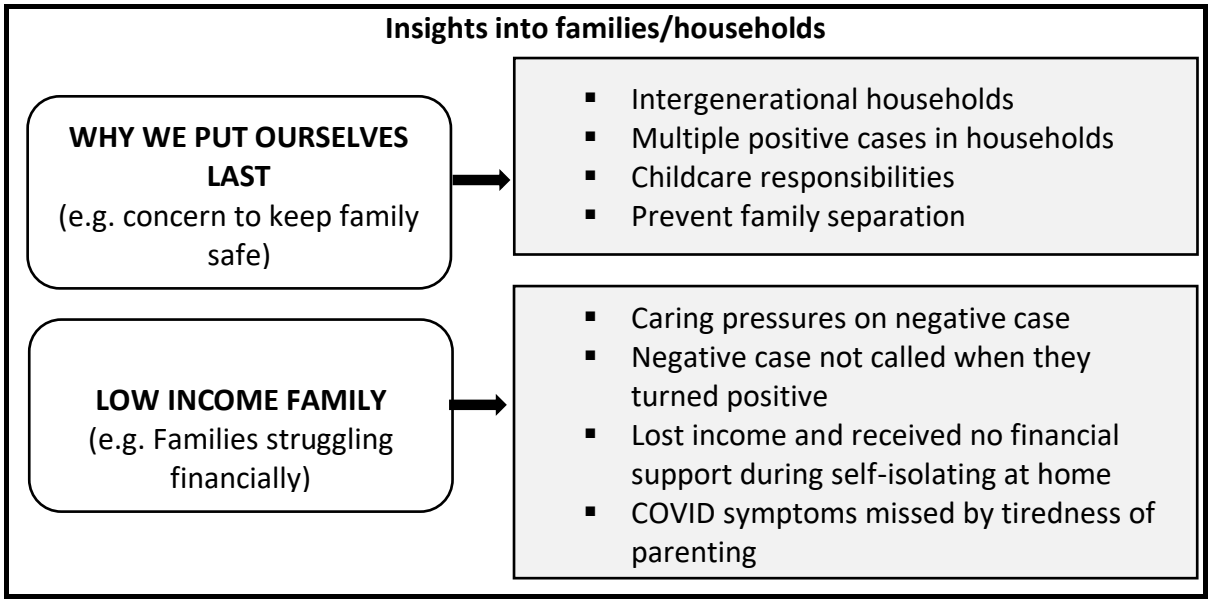
Why we put ourselves last	
Description	Frequency

Childcare responsibilities	6
Multiple positive cases in households	5
Intergenerational households	3
Seeking to prevent family separation	2
Total	41

Table 6. Low-income households

Low-income households	
Description	Frequency
Caring pressures on negative case	5
Negative cases not called or received support when they turned positive	3
Delayed testing as COVID symptoms were missed by tiredness of parenting	3
Lost income and received no financial support during self-isolating at home	4
Total	41

Figure 6. Insights into families/household model



Research participants tell stories of their combined financial hardship and complex family needs whilst self-isolating, often in intergenerational households or where there are multiple positive cases in a single dwelling. In

the extracts below, six research participants describe their set of circumstances at home, which provides a glimpse into how research participants were feeling going into a supportive conversation:

> “I live with my ... at my mother’s house … so I live with her. There’s also my wife and child. So far, the only people who have tested positive is my mother and me” (Male, aged 39, Sri Lankan).

> “… I live with three younger brothers and mum and dad, the first one to test positive was my youngest brother and then, through him, my other brothers got it, and then my mum and then I got it” (Male, aged 25, British Bangladeshi).

> "They were just calling for my wife, my kids, and mother in law, every time I have to answer the call, and it was like half an hour, half an hour, I have to repeat the same thing again and again” (Male, aged 39, Sri Lankan).

> “… my daughter tested positive, and then we all took the test at the same time, same day, and then we all came positive”.

> “I get a PCR positive test and started isolating. I didn’t go to work. I stayed at home because my wife was very sick [COVID]. She was in bed for two days, and I was at home with the kids and then after the kids got COVID also. Even maybe the dogs” (Male, aged 51, White other).

The above threads illustrate the challenges for the call handler to be heard when research participants are experiencing numerous intersecting issues concerning them.

The following selection of extracts provides an insight into the “real” and imagined fears and concerns that were experienced by research participants, and not always explicitly shared with the call handler. **For example, four research participants comment on their challenges with childcare:**

> “I’ve got a toddler who’s dependent on me. I don’t know who would look after my daughter” (Female, aged 29, British Bangladeshi).

> “… I have a pregnant wife, and she had severe symptoms and I needed to care for her and provide meals [for] my children. I told them [CRT], ‘listen, we're all having a very, very bad time with the coronavirus’” (Male, aged 37, British Bangladeshi).

> “… when you’re a parent with two children, tiredness doesn’t necessarily mean you’ve got COVID. It’s just [laughing], so it’s quite hard to know sometimes” (Female, aged 40, Indian).

> “Not that I needed it, but you know, like someone to be there if I was getting worse, maybe kind of just a quick check-in call would have probably been good” (Male, aged 44, White other).

Two research **participants stress the need to keep the family together, driving their decision not to accept hotel isolation:**

> “… because I am pregnant, no one felt comfortable letting me stay somewhere [hotel] on my own. Obviously, I’m quite heavily pregnant” (Female, aged 29, British Bangladeshi).

> “I was offered hotel isolation, but thought it was easier to stay home in my own room” (Male, aged 29, Pakistani).

Three research participants reflect on the caring pressures placed on the negative family member in the household:

> “... I think we were running out of groceries a little bit, I am the only driver, so I had to isolate since my brother had it [COVID]” (Male, aged 25, British Bangladeshi).

> “… except for my wife, even though she lives with us, she didn’t have it (Male, aged 49, Black British).

> “... he [husband] was working from home, a bit, but he was [also] looking after the children, so it was complicated” (Female, aged 40, Asian British).

Five research participants describe the **economic impact of self-isolating:**

> “my company pays my time. I was in the house with sick pay. So, I didn’t get any kind of support, I accepted it so. I wouldn’t have no problems with that” (Male, aged 28, Pakistani).

> "… two weeks of not working means no money, but you still have bills and rent to pay" (Female, aged 40, British Bangladeshi).

> “[I] lost income and received no financial support during self-isolating at home, normally I get around like £600 something salary, but that month I got like £200 something” (Male, aged 37, Asian British).

> “It was hard financially, as I lost income for two weeks while self-isolating. I lost money while isolating …” (Female, aged 26, Black African).

> “We had to order food from outside, and a lot of junk food and things like that, because nothing’s available and of course everyone’s taste buds are a little bit different, so you had to adjust for everyone’s sort of catering. Some people wanted soup, some people wanted something different, so it was a little bit more financially straining” (Male, aged 25, Bangladeshi).

There is a recurring story thread in the research participants' accounts of adhering to the government's self-isolating guidance – to prevent community transmission of the COVID-19 virus – but at the same time, they experienced the burden of caring for loved ones – especially in the case of the family advocate – along with reduced household income and the very practical challenges of accessing affordable food supplies. The supportive conversations have reportedly helped research participants to think through and navigate some of these practical daily challenges.

Case Study 1: Family circumstances

The participant is a 25-year-old male from a Bangladeshi background. The participant lives with his three brothers and with both of his parents. His youngest brother tested positive first, followed by his second and third brother (both in their 20s), then his mother and himself. The participant spoke with the welfare team on his mother's behalf. He said he mentioned to the call handler that he was the only negative person in the household. The welfare calls provided clear guidance on self-isolation rules to avoid further transmission, but could not establish the family's needs because the participant's mother was unwell, and they said they would call again. On the second call, the participant reported that he mentioned to the welfare team that he and his family would need some assistance and wanted to know what was available; however, the welfare team told him to talk with his mother, and promised to call him back, but they never did. There were caring pressures on him, as he said he told his father, who was away for work, to delay his return to avoid contracting the virus. The participant reported not being informed of food access or other available support by the friendly and polite call handlers. He looked after his three brothers and mother while working from home. He said he faced financial hardship, as he had to order different types of fast food daily to suit the needs of his four family members. He said it would have been good for his brothers and himself to receive Welfare Check-in calls.

4.2. Engagement themes where good reach is identified

Insights into access

By access, we are talking about how research participants perceived their own ability to engage and participate in the supportive conversations. The key themes/topics we explore are the family advocate, peer pressure, and communication and cognitive reasoning. All three ideas are considered as both enablers and barriers to access and participation. When asked what additional support would have enabled them to self-isolate more efficiently at home, research participants have occasionally reported a mismatch between their household's self-isolating needs and the support provided through the supportive conversation. Retrospectively, several of the research participants reported that their self-isolation needs could have been better

addressed if somewhere in the supportive conversation, time was taken to explain what services/resources were available to them. For example, most, if not all, research participants report being asked what help they might need to better self-isolate by the call handler, but without having full knowledge of the different types of support available. Several research participants reported being given information about services, whilst other research participants received no information to help them navigate the question and to provide an informed response.

Research participants also report that the full range of family needs was often overlooked by the family advocate taking part in the supportive conversation (e.g. only English speaker in the household). These research participants were sometimes asked to consider the needs of up to five household members in a single call (or in separate calls). A few research participants described struggling to answer this question. Added to this was the effort to filter and absorb all the information shared in the supportive conversation against the backdrop of highly pressured home environments. In contrast, the call handlers have been successfully able to move some research participants into a nurturing environment where the research participant has been able to tell the call handler what was needed. We look in more detail later at where the supportive conversations have worked best.

Research participants also reported the existence of peer pressure within the household, which has influenced how they have sometimes approached negotiating and navigating the supportive conversations. The appearance of peer pressure was conceptualised and discussed as both an internal/external regulation device in order not to break religious, cultural and family rules, and notions of normative standards of accepting help from organisations/people outside of familiar networks. In other words, research participants were happy to accept help from their extended family members and communities of interest, but not from unfamiliar or unsolicited individual/organisations. On rare occasions, research participants suggested that they were explicitly told by someone to limit their engagement with the Welfare Check calls (e.g. multi-occupancy household for single men or low wage owners) out of fear that the sharing of personal information would negatively impact on the family or livelihoods of other household occupants. The tables below show in descending order of importance the access/engagement issues that mattered most to the research participants to enable them to better self-isolate more efficiently at home.

Table 7. Family advocate

Family advocate	
Description	Frequency
Mismatch of need and support given	6
Unhappy with receiving multiple calls at different times of the day for single English speaker in household to handle	4
Call handler following script	3

Call handler did not interrogate to explore family living situation	2
Total	**41**

Table 8. Peer pressure

Peer pressure	
Description	Frequency
Religious and cultural justification to stay home	2
Peer pressure to limit sharing information in multiple occupancy dwelling	1
Total	41

Table 9. Communication and cognitive reasoning

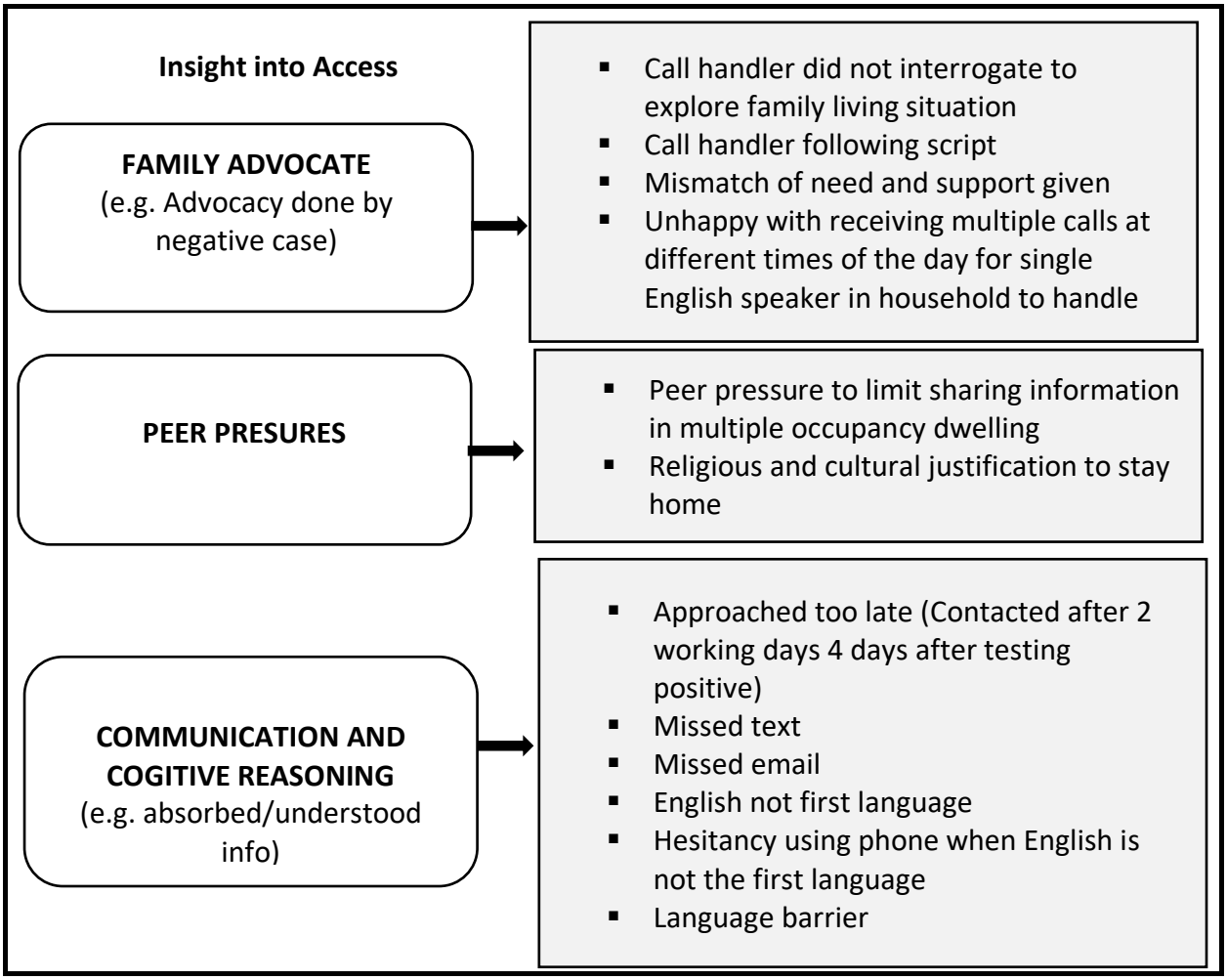
Communication and cognitive reasoning	
Description	Frequency
English not first language	31
Approached too late (Contacted after 2 working days 4 days after testing positive)	7
Hesitancy using phone when English is not the first language	7
Language barrier	7
Missed text	1
Missed email	0
Total	41

Case Study 2: Access

The participant is a 39-year-old male from a Sri Lankan background. The participant lives with his mother, his wife and his young son. Only the participant and his mother tested positive for coronavirus. The participant received the Welfare Check call because his mother tested positive, then he had contact with his mother, then he tested positive; as result of that, the welfare call was made to avoid further transmission inside their household. The participant was informed about self-isolation guidance; however, the participant declined the offer of welfare calls. The participant reported working for the NHS and being self-sufficient at home – he has a comprehensive sick leave package – so he declined the need for the support that the Council offered him – food and groceries delivery. The participant reported not being aware of other support, such as financial support or the Newham Hotel Isolation programme. The participant reported having limited contact with the welfare team, but the welfare team treated him with respect and in a caring manner. The participant reported that he did not leave his house at any time during his self-isolation period. The participant also reported being sceptical about the Council's competency, but stated that the Council are doing their best to get the job done. The participant reported that, in terms of access, the Council should create pamphlets with information about all the support options available for people like his mother, who has

dementia, and is not able to use technology due to her age (his mother is 80 years old), thus she is not technically savvy, so she was unable to access online resources suggested by the Council.

Figure 7. Insights into access model



To learn more about how research participants have accessed/engaged with the supportive conversations, we have arranged the participants' comments as follows:

One research participant describes the mismatch in support need:

> "It would have been good to get food support, as I spent a lot of money on fast food delivery" (Male, 25, British Bangladeshi).

Two research participants describe the challenges of being the family advocate:

> "… I think they phoned towards the end of the isolation ten days. They asked me if everything was fine, and I said, no I'm good. And I think they phoned again the last day of isolation. They asked if I needed anything, I said, no and then that was it really, there was no mid check, but I didn't ask [for] anything, there wasn't a need for it anyway."

> "… they called, she didn't say anything about isolation. She did ask if we need help with the food – they can organise – and someone can come and bring us the food, which we already had because before we tested positive, we did this big shopping so that we didn't [need] to go out. I also ordered some bits online

during the isolation period. Then she did ask about, if we were going to be paid or not? When I mentioned that my husband is self-employed, then she sent us a link".

One research participant describes his experience of peer pressure:

> "… she [wife] was worried, she thought she would catch it, you know. She was obviously worried, and obviously not only about herself, but also her whole family. At that time, people we were so scared of COVID … like me. I have an underlying [health condition]. I had a stroke in 2018, so everyone is kind of worried that you might not recover from COVID" (Male, aged 58, White British).

To summarise, we can conclude that the time taken to access/engage in supportive conversations has had its toll on the family advocate. The supportive conversation also caused the emergence of "peer pressure" – unknown to the call handlers – influencing what research participants said, and their decision making on the call. Finally, some research participants hint at communication problems. Many of the research participants were from Black and ethnic minority communities where English is a second language, and due to their health condition and symptoms, they reported that they sometimes found it hard to absorb all the information being shared with them in the supportive conversations.

Insights into information

This section looks specifically at what information was shared in the supportive conversations, and what type of support was needed from the research participants' standpoint. We asked research participants if they were aware of certain support services accessible through the Welfare Check calls, and how they found out about them. The tables below show in descending order of importance what mattered most to the research participants regarding their knowledge of support services. The key themes/topics that emerged are: when support was not needed; needs-led offer; and emotional support and service availability.

Table 10. When support was not needed

When support was not needed	
Description	Frequency
Asked what support they would like	33
People not suffering from adverse effects	11
Declined due to immediate needs being met	8
Did not believe in COVID, although tested positive	1
Total	41

Table 11. Needs-led assessment

Needs-led assessment	
Description	Frequency
Contacted within 0–2 days of being tested positive	15
Happily accepted Check-in calls support	11
Accepted food support	11
Accepted medication delivery	3
Total	41

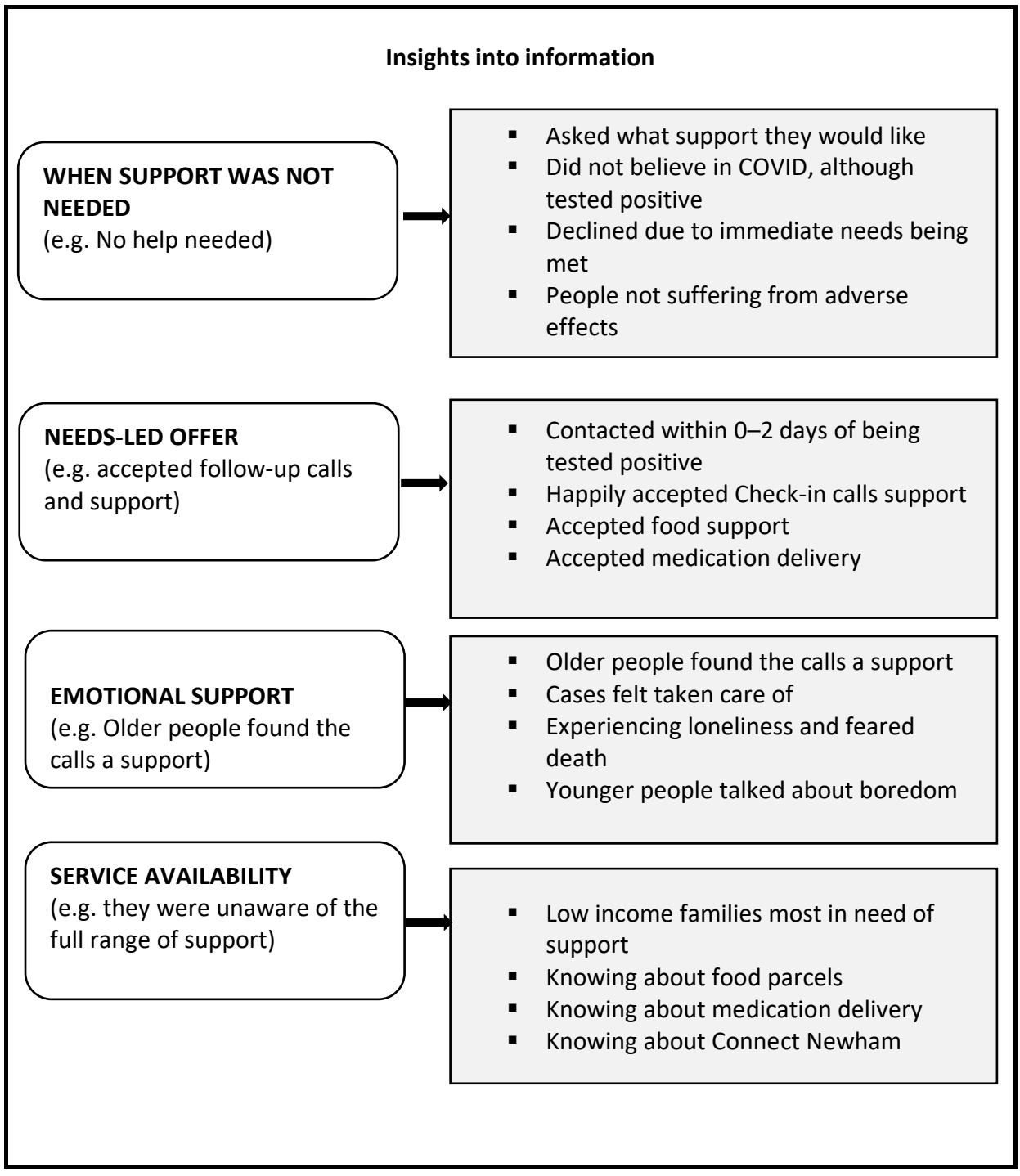
Table 12. Emotional support

Emotional support	
Description	Frequency
Experiencing loneliness and feared death	14
Cases felt taken care of	9
Older people found the calls a support	5
Younger people talked about boredom	4
Total	41

Table 13. Service availability

Service availability	
Description	Frequency
Knowing about financial or local microgrant support isolation payment	17
Knowing about food parcels	6
Knowing about medication delivery	4
Knowing about Connect Newham	3
Total	41

Figure 8. Insights into information model



As noted, the research participants have been highly appreciative of the supportive conversations, especially elements of the conversations that have helped them to find practical solutions to self-isolating problems. However, of equal importance to many of the research participants has been having knowledge about the full range of services available to them. Research participants suggest that written information – in different languages – would have helped them to better cognitively process the information shared with them, increasing their reflexive participation in the

conversations. Written information would have also enabled research participants to share information across the family (e.g. including ageing relatives) and, in so doing, lessen the burden of decision making. In view of that, participants suggest that they could have more actively participated in the supportive conversations when they felt fully informed.

Research participants also shared their stories about why they did not accept additional support when offered (i.e. beyond the self-isolation advice given in the Welfare Check call). A few research participants said that they declined additional support due to having enough resources to see them through their self-isolation period (e.g. sick-pay and savings). Other research participants said that they had support networks in place (e.g. WhatsApp groups and mosque). In the case of research participants who only experienced the supportive conversations, they pointed to its benefits in helping them feel less alone during self-isolating, and in overcoming the fear of death – especially among Black research participants. Five research participants share stories about why they declined additional support outside of the supportive conversation:

> “So, we were quite fortunate that we didn’t need any external help” (Male, aged 39, Black Caribbean).
>
> “I wasn’t aware of the whole range of options available, so maybe could be a bit clearer on that when they do call because I only needed a few options, but yeah, it would have been good to know the bigger picture, but yeah, apart from that, I was grateful that they called anyway” (Female, aged 36, White British).
>
> “I had enough resources and did not need additional support” (Male, aged 24, Pakistani).
>
> "I had people from mosque to help me” (Female, aged 4, Pakistani).
>
> "There are people with no support at all, and they would need more support than me" (Female, aged 72, White British).

We can see a set of common themes in the research participants’ stories about how they have responded to the offer of help in the supportive conversation. In the above threads, research participants reveal their intrinsic impulse to say “no” to help, when in fact a number of research participants might have benefited from additional practical, emotional and financial support.

Case Study 3: Information

The participant is an 84-year-old female from an English background. The participant lives on her own. In terms of health and wellbeing, the participant reported not feeling lonely or worried about the future. The participant reported no

coronavirus symptoms. The reason the participant got tested was because she planned to visit a friend who was looking after her mother, so she did not want to bring any illness to her friends' mother or her friend herself, so she went to get tested and the result was positive, so she had to cancel her plans and self-isolate for 10 days. The participant reported that she was impressed and really appreciated the Welfare calls, as they check if she needed any kind of help, such as picking up her medication and shopping for groceries, but the participant reported being fortunate enough not to need the help. In terms of compliance, the participant reported that during her self-isolation period, she left her house daily for a brief walk, but she complied with coronavirus rules by maintaining social distance when she saw friends in a park, she informed them she had tested positive. For example, the participant reported that she did not ask the Council for help because she was part of a neighbourhood WhatsApp group with people who would volunteer to do the participant's grocery shopping and deliver it to her doorstep. In terms of trust in the Council, the participant's perception of the Council is that they are doing quite well, and she saw the Council in a positive way.

To summarise, this section has considered the research participants' subjective perceptions of the information shared with them in their supportive conversations in order to make informed choices about how to better self-isolate. Generally speaking, research participants reported that they were informed about, and were able to access, a variety of provisions, including financial aid, food parcels, medication delivery and mental health support through the supportive conversation. Yet still, some research participants suspected that they lacked knowledge of the full range of support available to them. Information was given orally by the call handler, but the research participants' accounts suggest an inconsistency in the sharing of information (e.g. in terms of level, breadth and timing). The number of Welfare calls made to research participants also varied across the sample group. In most cases, the inconsistency in calls went unnoticed; few participants expressed any dissatisfaction (e.g. especially negative family advocates who turned positive), and some welcomed the absence of calls. There is no right answer to this problem, but it is defined by residents' needs versus service capacity.

The previous section has illustrated why participants have said "no" to further help. The tables below outline, from the research participants' perspective, which additional support (e.g. financial, microgrants, befriending, food, medicine, health and self-isolating advice) have been taken up by research participants through the supportive conversations based on their gender, age and ethnicity.

Table 14. Gender and financial support awareness

		Number of research participants aware
Gender	Female	6
	Male	5

Table 15. Age and financial support

		Number of research participants aware
Age	21-25	5
	26-30	1
	36-40	3
	46-50	1
	66-70	1

Table 16. Ethnicity and financial support

		Number of research participants aware
Ethnicity	Asian - Bangladeshi	1
	Asian - Other Asian	1
	Asian - Pakistani	1
	Asian Indian	2
	Black - African	2
	Black - Caribbean	2
	Mixed - White and Asian	1
	Other White	2

The profile of research participants aware of financial support is more female than it is male, between 21 and 25 years old and Asian, predominantly of Indian descent.

Table 17. Gender and microgrants

		Number of research participants aware
Gender	Female	6
	Male	4

Table 18. Age and microgrants

		Number of research participants aware
Age	16-20	1
	21-25	4
	31-35	1
	35-40	1
	36-40	2
	56-60	1

Table 19. Ethnicity and microgrants

		Number of research participants aware
Ethnicity	Asian - Other Asian	1
	Asian - Pakistani	2
	Black - Caribbean	1

	Mixed – White and Asian	1
	Other White	2
	White British	1
	Missing data	2

The profile of research participants aware of microgrants is female between 21 and 25 years old, of either Asian of Pakistani descent, or White of non-British descent.

Table 20. Gender and befriending

	Number of research participants aware	
Gender	Female	6
	Male	1

Table 21. Age and befriending

	Number of research participants aware	
Age	16-20	1
	21-25	1
	35-40	1
	36-40	1
	46-50	1
	56-60	1
	81-85	1

Table 22. Ethnicity and befriending

	Number of research participants aware	
Ethnicity	Asian - Bangladeshi	1
	Asian - Pakistani	1
	Asian Indian	1
	Other White	1
	White British	2
	Missing data	1

The profile of research participants that were aware of befriending support was female Asian (no predominant descent) or White British between the ages of 16 and 85.

Table 23. Gender and food support

	Number of research participants aware	
Gender	Female	7
	Male	9

Table 24. Age and food support

	Number of research participants aware	
Age	16-20	1

	21-25	5
	31-35	1
	35-40	1
	36-40	2
	46-50	2
	56-60	1
	61-65	1
	66-70	1
	81-85	1

Table 25. Ethnicity and food support

	Number of research participants aware	
Ethnicity	Asian - Bangladeshi	1
	Asian - Pakistani	2
	Asian Indian	2
	Black - African	3
	Black - Caribbean	3
	Other White	2
	White British	2
	Missing data	1

The profile of research participants that were aware of the food support service was male, between the ages of 21 and 25 and Asian (of Indian and Pakistani descent) or Black (no predominant descent).

Table 26. Gender and medicine access

	Number of research participants aware	
Gender	Female	5
	Male	5

Table 27. Age and medicine access

	Number of research participants aware	
Age	21-25	1
	26-30	1
	31-35	1
	35-40	1
	36-40	2
	41-45	1
	46-50	1
	61-65	1
	81-85	1

Table 28. Ethnicity and medicine access

Number of research participants aware

Ethnicity	Asian - Bangladeshi	1
	Asian - Other Asian	1
	Asian - Pakistani	2
	Asian - Indian	1
	Black - Caribbean	1
	Mixed – White and Asian	1
	Other White	2
	White British	1

The profile for research participants aware of medicine access support is even in terms of gender (no predominant gender), evenly distributed amongst age groups, but with more frequency between the ages of 36 and 40 and Asian, predominantly of Pakistani descent.

Table 29. Gender and self-isolation

	Number of research participants aware	
Gender	Female	5
	Male	1

Table 30. Age and self-isolation

	Number of research participants aware	
Age	16-20	1
	21-25	3
	26-30	1
	36-40	1

Table 31. Ethnicity and self-isolation

	Number of research participants aware	
Ethnicity	Asian - Bangladeshi	1
	Asian - Pakistani	1
	Asian - Indian	1
	Black - African	1
	Black - Caribbean	1
	Mixed – White and Asian	1
	White other	1

The profile for research participants aware of self-isolation support is predominantly female, aged 21 to 25 years old and Asian or Black (No predominant descent).

Table 32. Gender and health advice

	Number of research participants aware	

Gender	Female	17
	Male	15

Table 33. Age and health advice

	Number of research participants aware	
Age	16-20	1
	21-25	10
	26-30	1
	31-35	2
	35-40	1
	36-40	5
	41-45	2
	46-50	3
	51-55	1
	61-65	2
	66-70	2
	81-85	1
	Missing data	1

Table 34. Ethnicity and health advice

	Number of research participants aware	
Ethnicity	Asian - Bangladeshi	3
	Asian - Other Asian	1
	Asian – Pakistani	2
	Asian Indian	4
	Black - African	6
	Black - Caribbean	3
	Black - Other	1
	Mixed – White and Asian	1
	Other White	10
	White British	1

The profile for research participants aware of health advice is female aged 21 to 25 years old and Asian, of Bangladeshi or Indian descent, or Black of African descent, or White of non-British descent.

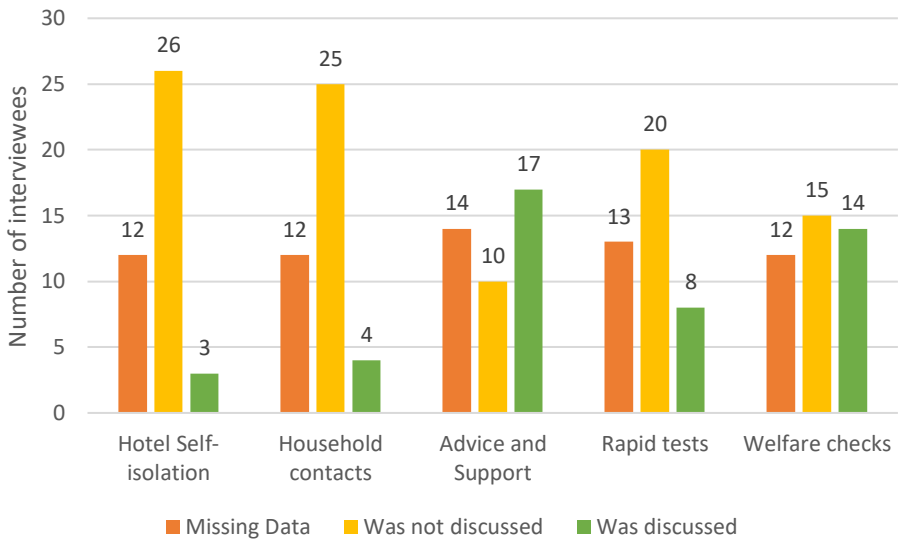
Awareness for the different services/resources reached its peak in September, the month when most of the supportive conversations took place, except for Safe Isolation and Food Support Awareness, which saw their biggest awareness in August.

Most of the research participants (a total of 24 research participants) acknowledged and enjoyed the supportive conversation as part of their Welfare Check-in calls; 17

research participants reported a conversation where they got advice and support; from which 3 research participants asked for fewer calls.

In contrast, rapid tests were discussed with only 8 research participants, hotel isolation for household members was discussed with only 4 participants, and hotel self-isolation for the call recipient was discussed with only 3 participants (Figure 9). (Please note: this interview question was changed mid-way through the interviewing process since not all the options were offered on the call and therefore should not be considered as missing data)

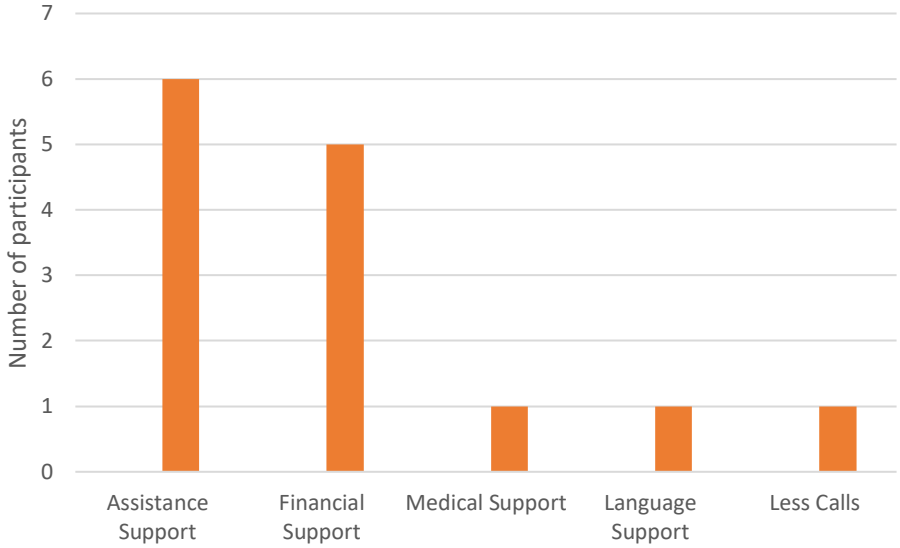
Figure 9. Welfare Check calls with research participants: issues discussed



Participants reported Welfare Checks and advice and support were the issues most discussed, while hotel self-isolation, self-isolation help for household members or provision of rapid test were commonly reported as not discussed.

Of the 41 research participants, 6 (15%) participants, suggested assistance support for household chores, groceries and other day-to day-activities that might have been disrupted by self-isolation; 5 (12%) participants suggested more financial support for those whose personal economies might have been disrupted by the pandemic. Around 7% of the sample group suggested other additional support initiatives, such as medical support or non-English-language information, specifically for Asian languages such as Urdu or Tamil. One participant asked for fewer calls (Figure 10).

Figure 10. Additional support suggested by the interviewees



In conclusion, the evidence suggests that the supportive conversations have been effective in connecting research participants to the right support/resource, despite sometimes lacking information on the full range of provisions. Research participants were also successfully signposted to community-based services as well, as supported with food deliveries etc. However, engaging effectively with different households, often through the help of one family member, has not always guaranteed that the right information has reached the right person in the household and the right need has been elicited. Remembering that many of the research participants were suffering boredom in self-isolation, they were grateful for the opportunity to experience a compassionate and motivational talk with the call handler. However, in the case of this pilot programme, further work is needed to better understand the resourcefulness in the help provided.

4.3. Learning where good reach is identified

Insights into trust and quality

In this section, we look at the research participants' subjective accounts of the Council's response to providing the Welfare Check calls. The key themes/topics we explore are political awareness and attitudes towards the Council as they relate to supportive conversations. Research participants' experience of the Welfare Check calls did not noticeably change their pre-existing attitudes towards the Council. Research participants positively reported that they were surprised and appreciative of the Welfare Check calls. Research participants also reported that they were far more distrustful and critical of the information and the actions made by central government than that of the local government. What we can observe in the research participants' accounts is how the Welfare Check calls produced a little nudge or slight push in an upward trajectory resulting from the research participants' perceived

level of care by the Council through the Welfare Check calls. There is certainly no evidence to suggest a decline in trust in the Council as a result of exposure to this provision. The tables below show in descending order what elements of trust and quality mattered most to the research participants.

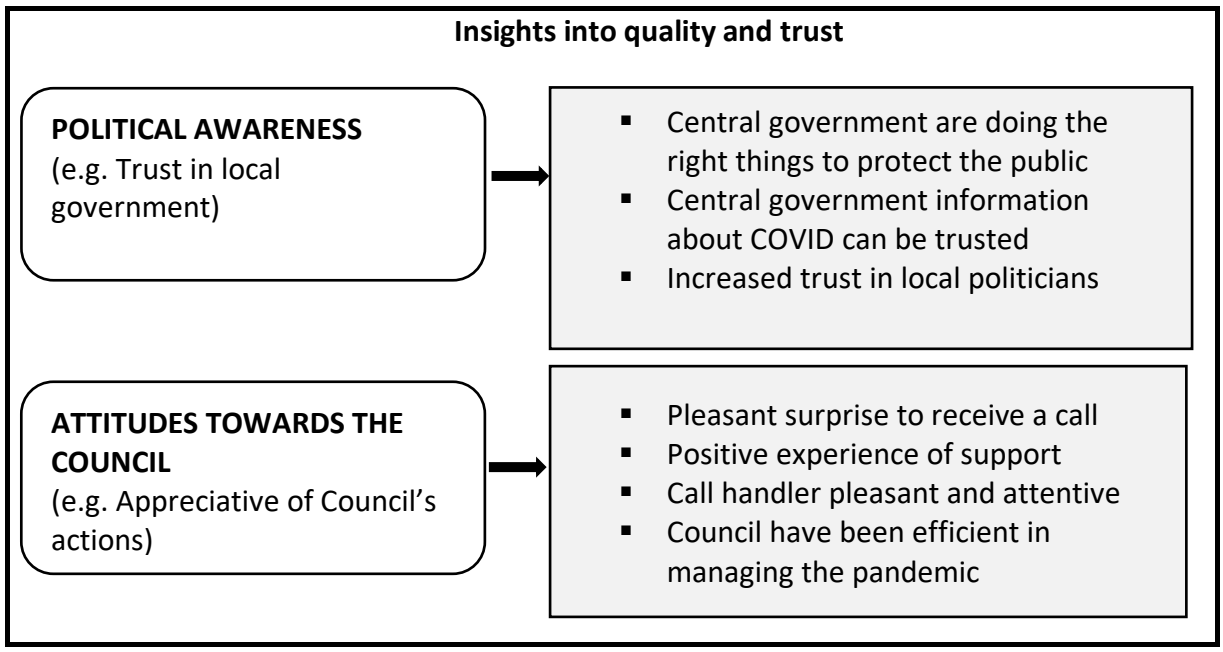
Table 35. Political awareness

Political awareness	
Description	Frequency
Central government are doing the right things to protect the public	25
Central government information about COVID can be trusted	20
Increased trust in local government	18
Total	41

Table 36. Attitudes towards the Council

Attitudes towards the Council	
Description	Frequency
Positive experience of support	32
Council have been efficient in managing the pandemic	28
Call handler pleasant and attentive	12
Pleasant surprise to receive a call	8
Total	41

Figure 11. Insights into quality and trust



Overall, the research participants' responses to the supportive conversations have been positive, and they have been motivated by and large to take part in the supportive conversations in order to protect family members from COVID-19, as well as for help with caring for dependents. A group of research participants comment on the perceived care they received from the Council:

> "I was impressed with Newham, a couple of people rang me to ask if I needed any help" (Female, aged 83, White British).

> "… Newham team, who was calling me. She called me and asked me, 'How are you feeling?', 'Feel better today?' I was telling, 'Yes everything is okay, I'm just sleepy and hungry.' So, she told me okay, I'll check on you tomorrow" (Female, aged 33, White British).

> "… it was really good. I mean the people from Newham, they phoned me every day which was really good. That really made me feel like I was being looked after and Test and Trace also phoned me. I did one time have a medical person who phoned me because I had some symptoms" (Male, aged 49, British Bangladeshi).

> "They checked on me every day, that helped with feeling of loneliness during isolation" (Female, aged 20, Indian).

> "My opinion about the Council has become more positive" (Male, aged 70, British Bangladeshi).

> "We didn't receive lots of support, so not much has changed to be honest" (Male, 38, British Bangladeshi).

> "I was really grateful that they called" (Female, aged 72, White British).

In contrast:

> "… they followed a script and would ask the same questions repeatedly. They were calling to remind me about isolating, not asking how I was. The calls were not really helpful, they were just doing their routine checks regardless of how I was feeling. I had to go through the same questions with NHS and then Newham" (Female, aged 49, British Bangladeshi).

Two research participants remarked on their mistrust of central government:

> "I think its self-serving. Yeah. I guess that's a good word, I think the choices made were not in the public's interest, but in their own" (Female, aged 37, White).

> "… the government, whether I trust them, it all comes down to the conspiracy like, what is COVID, was it manmade, why is that they can't tackle it after two

and a half years or so, why is that after so many people getting vaccinated they still fall ill …?" (Female, aged 29, Bangladeshi).

The following extracts show the research participants' thoughts and feelings about how information was shared in the supportive conversations.

Five research participants reference the importance of presence in the call handler:

> "Her name was Mary and she did everything, she was amazing. She did everything by herself, she took my information … she checked with me for everything except financial. I never got anything about financial [help]" (female, aged 28, White British).

> "I didn't mind, but for other people will benefit from check-in calls in between too" (Female, aged 22, Pakistani).

> "I only needed a few options, but yeah, it would have been good to know the bigger picture" (Male, aged 38, White British).

> "They need staff to be fully trained, as they didn't ask me about my living situation" (Male, aged 70, British Bangladeshi).

> "If I knew in the beginning, I would have used the Council instead of calling family or friends" (Male, aged 49, Black African).

> "Council should provide a leaflet about the service, but that might be too expensive to do" (Male, aged 49, Black African).

> "She heard me coughing, but carried on asking questions, as they just wanted to do their job" (Female, aged 49, British Bangladeshi).

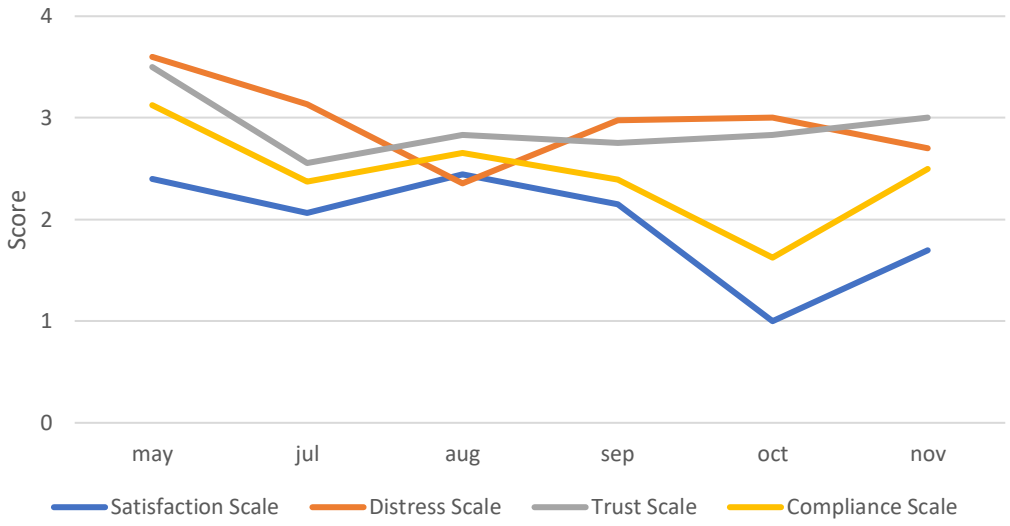
> "My contact with Welfare people was limited to begin with, and because, and there's been no continued contact between me and the Welfare people. I have neither, erm, good nor bad opinions about them" (Male, aged 39, Sri Lankan).

Case Study 4: Quality and trust

The participant is a 44-year-old male from a European background. The participant lives with his partner. In terms of health and wellbeing, the participant reported feeling anxious while self-isolating because he kept worrying that he would get worse symptoms, or he was worrying about dying from coronavirus. When the Newham COVID Response Team called for the first time, they asked him if he was fine and needed any food, but the participant reported that he had already ordered some food online. When the Newham COVID Response Team called for the second time at the end of his self-isolation period, the participant reported that again they asked him if he was fine and needed anything, but the participant said that no, he didn't need anything. The call handlers were polite and friendly;

however, the participant reported that it would have helped him to self-isolate more effectively if he had received daily calls to check on his health, in case his symptoms got worse. In terms of compliance and trust, the participant reported that initially he had a sore throat, so he still went to work, but on the following day he tested positive for coronavirus, so he started to self-isolate straightaway. The participant reported having a positive experience with the Welfare Support Service, and it was great that the Council offered the support. However, the participant recommends areas for improvement; one was to bring more awareness of which services were available, such as the hotel offer.

Figure 12. Self-isolation period amongst research participants and associated scores on the four scales



In summary, research participants had a mixed response to the quality of the supportive conversations. From the research participants' perspective, open and honest communication has been highly appreciated, which simply means being transparent and giving information on the available provisions. Also, research participants would have liked to have seen better language support and medical advice as part of the supportive conversation. For instance, some research participants wanted to know about milestones or markers of coronavirus, and noted that the call handlers were not trained medically to offer more support with COVID health literacy.

Research participants would also have liked to have experienced better coordination mechanisms related to the timing and frequency of the calls; for example, receiving a Welfare call from the call handler was not that helpful when different team members were calling several times during a single day. Some research participants with more than one positive case only received Welfare Check-in calls for the whole family,

whereas other research participants received separate calls for each family member. One research participant said that he was tired of long calls made for each of his five family members at different times of the day, when his pregnant wife was very unwell and he needed to attend to his young kids. Other research participants suggested that they felt fed up and frustrated, especially when they were trying to rest. In contrast, research participants who answered calls on behalf of their family and later tested positive said that they felt neglected when they did not receive a Check-in call about them and could not understand the reason why this did not occur. A few participants identified that they only received a call at the end of the self-isolating period and could not take advantage of much-needed help.

Research participants have also stated the challenges of participating in supportive conversations whilst experiencing breathing problems due to COVID. Specifically, they have felt that the duration of Check-in calls was too long. For example, a research participant suffered long-COVID and took a very long time to recover, experiencing reduced cognition and fatigue. She was bed bound for around two months and experienced long calls. Research participants had issues with the call handlers self-evident use of a script. This stopped the research participant from slipping into a naturally flowing discussion/conversation, in which they could tell their story and build empathy with the call handler. Finally, a gap in provision highlighted by the research participants has been for research participants with complex health and social care needs – such as childcare responsibilities, dementia and autism – who struggled to access the right support in order to better self-isolate. Thus, accessing the right support service through the supportive conversations has not always led, from the research participants' perspective, to the right provision at the right time.

Perceived benefits and impacts of the services, including service users' assessment of the quality of the intervention

Insights into improvements

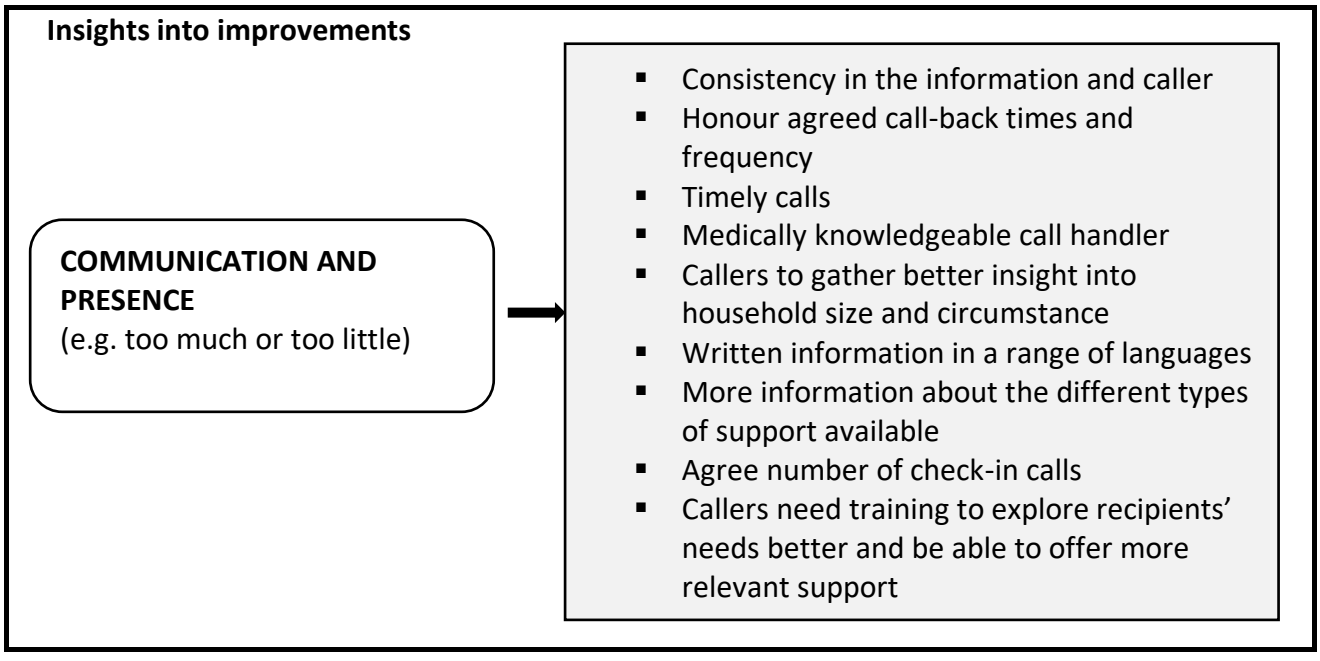
This section considers where features of the supportive conversation could be improved based on the research participants' subjective perceptions. The key themes/topics we explore are communication and presence as they relate to the supportive conversations. In the research participants' accounts, we can observe several frequently reported weaknesses. For example, research participants comment that call handlers should try and gather more insight into household size and circumstances. This level of information, combined with a consistent call handler, would have helped the research participants in managing the calls alongside other household responsibilities. Also, call handlers should have factored

in the number of positive cases in the household in their response, and ensured that they also contact family advocates whose status changes to positive. As previously mentioned, more information about the different types of support available is highlighted as important. Crucially, having access to written information about the services available in a range of locally spoken languages would have helped research participants to access services. The tables below show in descending order of importance what improvements mattered most to the research participants.

Table 37. Communication and presence

Communication and presence	
Description	Frequency
More information about the different types of support available	29
Consistency in the information and caller	9
Timely	9
Agree number of check-in calls	9
Callers to gather better insight into household size and circumstance	5
Written information in a range of languages	5
Callers need training to explore recipients' needs better, and be able to offer more relevant support	4
Honour agreed call-back times and frequency	3
Medical knowledgeable to be shared by call handler	2
Total	41

Figure 13. Insights into improvements



Case Study 5: Improvements

The participant is a 23-year-old female from an Eastern European background. The participant lives with her mother and little sister. Only the participant and her sister tested positive for coronavirus. In terms of health and wellbeing, the participant reported feeling lonely and worried about the future while self-isolating. The participant took the Welfare Check offer as she was the only positive case at the time; thus, to avoid further transmission in her household, she took the offer. The participant reported that call handlers were polite and friendly, however, the call handlers did not inform the participant of the full range of options. such as rapid lateral flows tests delivered to her household. She was irritated when she found out about this option because if she had known about it, she would not have needed to go to a hospital to get tested. The participant also reported that her experience of the Welfare Check-in calls has positively changed her views of the Council, however she wished that the Council had given her more time and information on the offered services. The participant said that areas for improvement could be to provide a leaflet with information about mental wellbeing during self-isolation or CBT sessions, as she struggled with her mental health. She also said that the Council should offer help with food delivery, as she could not order groceries sometimes as her mind was not quite there and everything seemed a big effort.

We now turn to consider held data (e.g. a selection of practitioner case and service reflection notes) sourced from the COVID Response Team. The cases reported by the COVID Response Team do not match the research participants per se, but they add contextual understanding of the team's reflexive practice and a diametrical opposing viewpoint into some of the matters that concern the research participants. The report provided by the COVID Response Team highlights several cases that the Response Officers have recorded from November 2020 to January 2022. The Response Team reported about the friendly conversations they had with the recipients, and if they were referred for practical support. In some cases, emergency support was called for cases.

The recorded cases display an overall satisfactory response from recipients, with a great number of reports including notes detailing expressions of gratitude from those who received the check-in calls, some of which are directly quoted from testimonial emails or social media messages received by the Response Team. Some recipients spoke about their reinforced sense of trust and gratitude towards the Council. The notes also highlighted the team's ability to communicate with residents in their languages, including Hindi, Bengali, Romanian, Urdu and Spanish.

Table 38. Timeline

Timeline	Reported case notes per month
Nov 2020	4
Dec 2020	3
Jan 2021	14
Feb 2021	5
Mar 2021	7
Apr 2021	4
May 2021	2
Jun 2021	7
Jul 2021	8
Aug 2021	17
Sep 2021	21
Oct 2021	12
Nov 2021	11
Dec 2021	12+ (1 did not answer)
Jan 2022	12

There is a lack of consistency in the way the cases are reported, with some notes only mentioning the detail of the call itself. In some cases, it seems that there was a need of a plan for follow up, or that there may be more to be done (provide food/talking therapy/language support) than the action taken to ensure the needed support was provided.

Based on the practitioners' characterisation of delivering supportive conversations, Table 41 summarises the key normalisation process/mechanism/functions of the supportive conversations/Welfare Check call that worked well and worked less well in the set-up and delivery of the pilot programme.

Table 39. Thinking about implementation of supportive conversations using normalisation process

Core concepts	Exemplifier of good implementation
Coherence	Need for integrated IT system – not spreadsheets – with better governance and efficiencies The percentage of residents needing support to isolate went above 30% in April and June, but in each month has consistently been more than 20% of cases reached.

	Financial support is the most commonly requested support, followed by help to access food. Financial support could be helping to apply for NHS Test and Trace Payment, or Newham's Stay Home Support Payment. It could also be follow-up with rejected applications, or linking resident to Our Newham Money for help accessing benefits/furlough etc. During November, we have seen an increase in requests for food support.
Cognitive Participation	Need for a 7-day a week service to reach people as near to test date as possible Observations from the team during the summer period: they saw greater reluctance to engage, but also, they experienced set-up challenges during July/August The CRS team have less success in reaching cases aged 20–39 years. A higher percentage of people of Asian (71%) or White (69%) ethnicity were reached, compared to people of Black (60%) or Mixed (61%) ethnicity. A higher percentage of people of Black Caribbean ethnicity were reached for a Welfare Check than Black African. Black African men were less likely to be reached than Black African women, but also than Black Caribbean, both men and women.
Collective Action	Recognising the fragility of team of redeployed staff needing to return to BAU. Need for multilingual skilled welfare connector is critical
Reflexive Monitoring	Need to develop a service which can meet rapidly changing case numbers The percentage of residents reached has steadily increased across all age groups. Between March and May, the CRM team reached more women than men. We have seen this difference in reach narrow over time.

To summarise, the evidence suggests that the areas for improvement should be focused on building collective action that would ensure a consistent approach across the Response Team in order to achieve a unified approach. The COVID Response Team's observations correlate with the research participants' priority points. This

includes how continual changes in processes are communicated, allowing the service to continue evolving as residents' needs and Government guidance change. It is also important to ensure that Newham residents are aware of the service and support services that might be available to them via targeted leafleting, the Council website, social media and other local publications.

4. Discussion

In this study, the research participants have shared stories of both gratitude and dissatisfaction with the Welfare Check-in calls. **Research participants have emphasised the economic, social, physical and emotional effects of self-isolating, and how they have been grateful to receive support through the Check-in calls.** We have also learnt from the research participants that there have been benefits and challenges of engaging in supportive conversations during the pandemic. **The supportive conversations have been successful in addressing research participants' immediate questions and concerns,** and have also been able to leverage research participants' community-based support services/resources when needed. **Whilst the Welfare Check-in calls were considered good in their speed of response (although less so in terms of reliability), the call was not always considered good for its comprehensiveness (detailed later).**

Also, evident in the findings is that research participants on the whole adhered to government guidance and started self-isolating as soon as symptoms were first recognised, and received a vetted COVID-19 test soon afterwards. Evidence also suggests that many of the research participants were first contacted for a supportive conversation in time to support them in self-isolating to contain the spread of virus. Most of the participants were contacted within two days after first testing positive spread and a few research participants contacted at the end of their self-isolating period. The majority of research participants reported that they felt happy about the support provided by the Council, and about receiving regular check-in calls. **As a result, qualitatively many of the research participants said the Check-in calls made a difference to their sense of wellbeing and knowledge, and that the Council was doing a good job in managing the COVID situation.**

In terms of the research participants assessment of the service acceptability, appropriateness and accessibility, **the Welfare Check-in calls were considered good in terms of speed of response (and less so in terms of reliability), but they were not always considered good quality based on their comprehensiveness.** Information gathered from the COVID Response Team and research participants points to weak collective action in the piloting of the service, which has impacted the implementation of an equitable, accessible and consistent Welfare Check-in service that meets the changing needs of all research participants.

Evidence suggests that collective action - the ability for the call handlers to work in a coordinated way - is the single biggest area for service improvement underpinning the concerns raised by the research participants. However, we know that the small response team was quickly assembled in response to the health emergency and made-up of redeployed staff and before becoming an established team. There are no benchmarks for evaluating the performance and quality of conducting supportive conversation as part a Welfare Check-in call during a pandemic. **Other COVID-19 Welfare check-in calls models are in existence focused on providing health and wellbeing support to the homeless or students and delivered by peer advocates or care navigators.** However, none of these pilots have yet published evaluation results on their effectiveness. The evidence collected and later organised around the five key areas of family, access, information, trust/quality and improvements provides rich and valuable insights into where the Welfare Check-in calls can serve as a supportive intervention in the lives of residents self-isolating. We have learnt that the main barriers to effectively self-isolating at home are **a combination of factors, such as struggling with multiple positive cases in a single household, financial hardship, struggling with isolation and boredom, as well as finding routine domestic tasks and caring responsibilities difficult to maintain.** The research participants' accounts show how access, information and quality of the telephone service has overall been effective in addressing their self-isolating needs, and have, as a by-product, served to reinforce family resilience.

In this study, **we have seen a moderate level of community transmission within the research participants' households during the period of the Check-in calls. However, from a different viewpoint, we can also see an increase in COVID health literacy awareness.** What is also evidenced, is that research participants have not passively taken part in supportive conversations. Power differentials between the call handler and research participant exists, and should not be ignored. Especially since the nature of the calls are inbound, and the research participant has no control over if or when the received their first call. Unsurprisingly, during the national lockdown, people felt powerless (see Williams et al., 2020), and the more powerless people feel, the more likely they are to adjust their aspirations regarding what they can reasonably expect to gain in such exchanges. However, **what is revealed in this study is that dependency relationships did not develop between the call handers and research participants.** This finding helps to explain how and why research participants felt both gratitude and dissatisfaction with different aspects of the Welfare Check-in calls.

We can also conclude that the amount of time taken to engage in supportive conversations sometimes took its toll on the family advocate, and some research participants also experienced "peer pressure" influencing what was said and their decision making on the call. As a solution to the barriers - and of great importance to many of the research participants - has been having knowledge about the full range

of resources/services available to them. **Research participants felt that written information – in different languages – would have helped them to better cognitively process the information shared with them, which would have likely increased their reflexive participation in the conversations.**

It should come as no surprise that one of the key areas for improvement should be on the sharing of information, which has been considered as ad hoc, and failed to fully meet the research participants' expectations. Despite these two significant challenges, research participants have valued and benefited from how the call handlers have been able to place them at ease, and overall have provided a responsive service. **The call handlers were considered by research participants to have been a good representation of the Council, being a channel for them to communicate their concerns.** The Welfare Check-in calls have undoubtedly created a sense of good will between the research participants and the Council, helping to positively nudge levels of trust upwards (see Devine et al., 2020; Davies et al., 2021; Woelfert and Kunst, 2020). This sentiment is reflected across generations, gender and ethnicity in the sample pool, and is demonstrated in their continued engagement with the service.

5. Conclusion

Do the Welfare Check-in calls do what they are supposed to do? Paramount to the research participants' engagement in the Welfare Check-in calls and uptake of additional resources/support has been a desire to protect loved ones and prevent family separation and help with household practicalities and finances. Based on the evidence, several key factors have emerged that have made the Welfare Check calls acceptable, accessible and adequate in helping research participants to better self-isolate. **Research participants have most valued: inbound calls; consistency in call handlers; polite and friendly call handlers; clearly communicated introduction to the service with language tailored to the research participant's age category and language spoken; text and emails have often been missed, so calls are highly valued; timely placed calls when help is most needed; streamlining calls to multi-case households; being empathetic, and the willingness of the call handler to deviate from the script; and through the conversation being able to build COVID-19 health literacy.** Without a doubt, research participants have successfully accessed a wide range of support services leveraged through the calls to better self-isolate, while they also experienced times when the call handler could not help.

Based on the representative ness of the sample group of the research population, we can deduce that this group of research participants were not outliers. We can see that many of the households contacted by the CRT were finding self-isolating difficult due to multiple cases in a single household, caring for dependents and financial

hardship. **Research participants have cited financial hardship and isolation as being the two biggest challenges during self-isolating.** Whilst the supportive conversations have evidently helped to increase awareness about how to self-isolate at home, they have also quietly helped research participants overcome the fear of death from the virus. Research participants have provided a wide range of opinions and viewpoints on their interaction with the service. **Issues of oral communication, timing and volume of calls, along with the quality and scope of the information shared in the supportive conversation should be addressed to strengthen this and other similar services.** Crucially, valuable lessons have been learnt in how to effectively engage and provide personalised support to vulnerable residents that can be scaled-out and applied elsewhere in the system.

Limitations

This is a relatively **small sample of 41 participants**, where omissions might impact the results. On occasion, the participants would decline to answer, or would not give a clear enough answer, which results in omissions. Sampling might have helped to mitigate the effect of the low number of cases; nonetheless, a higher number of cases would be more desirable for representativeness.

A few telephone interviews required a proxy to translate/communicate the question, and to gather a response, due to language barriers. These were often the persons mediating the telephone call during the Welfare Checks, and possessed much of the information we needed to be provided as part of the interview. We also conducted paired interviews, when one or both participants had received Welfare Check calls.

A few participants who were willing to take part in the study were not included due to the length of time before they would be first available – some of the appointments had to be booked a long way ahead, but they could not make it any earlier.

Despite young people aged 18-19 making up 7% of the positive test register, **we had low up-take for interviews** and/or were not able to contact them due to a high level of cancelled mobile numbers.

Not all the residents contacted on the register remembered receiving a Welfare Check call from the Council. Most significantly, the name of the service was not always recognised by the potential research participants. This was due to a relative answering the call on their behalf during their period of ill-health, the lapse in time between receiving the call and being invited to take part in the study, and, finally, the experience of COVID having distorted their memory, not only of the call, but also of key facts leading up to being tested positive.

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Appendix 1: Postcodes profiling

E12

E12 is a postcode mostly composed of terraced houses (41% of all housing) and flats (28% purpose-built and 11% converted) which can be best described as a medium-density area. Temporary or improvised housing is scarce (less than 1%), as are detached (7%) and semi-detached (10%) premises.

Table x.1 - Housing development in E12

Detached	Semi-Detached	Terraced	Flat (Purpose-Built)	Flat (Converted)	Residence in Commercial Building	Caravan, Park or other Temporary
978	1370	5498	3784	1413	342	8
7%	10%	41%	28%	11%	3%	0%

Most housing premises in the area are rented in any of its diverse forms, with an overall 41% ownership (18% completely owned and 23% owned with mortgage); 16% of the housing premises are council rented, with 7% rented by social organizations (such as charities). The majority of rent is overwhelmingly private (32%).

Table x.2 - Housing tenure

Owned Outright	Owned with Mortgage	Shared Ownership	Rented: From Council	Rented: Other Social	Rented: Private Landlord, inc. letting agents	Rented: Other	Rent Free
2317	3093	115	2108	983	4187	192	176
18%	23%	1%	16%	7%	32%	1%	1%

House occupancy is low, with 34% of premises housing five individuals or more. Premises housing a single person amount to 22%, and those housing two people amount to 19%. Only 3% of housing premises are registered as housing more than eight persons.

Table x.3 - House occupancy

One Person	Two People	Three People	Four People	Five People	Six People	Seven People	8+ People
2943	2547	2015	2223	1581	1094	405	363
22%	19%	15%	17%	12%	8%	3%	3%

This is an area that is predominantly working class, with 55% of its population located on the lower part of the social grade classification: 17% described as skilled manual workers, and 38% (the highest proportion) described as semi-skilled or unskilled manual workers, as

well as unemployed individuals or recipients of benefits and/or assisted income. However, middle managerial workers make the second highest position, with 29% of the total population.

Table x.4 - Social Grade

AB - Higher and intermediate managerial, administrative, or professional positions	C1 - Supervisory, clerical, and junior managerial/administrative/professional positions	C2 - Skilled manual workers	DE - Semi-skilled and unskilled manual workers; those on state benefit/unemployed, and lowest grade workers
1783	3210	1908	4273
16%	29%	17%	38%

An overall majority reported being in good health, with 48% reporting very good health and 34% reporting good health; 2% of the population reported having very bad health.

Table x.5 - Population health

Very Good	Good	Fair	Bad	Very Bad
20918	15005	5301	1825	722
48%	34%	12%	4%	2%

The age distribution of the population in this area is firmly middle aged, with 59% of the population being between 20 and 59 years, of which 10% is in the range between 20 and 24, 12% is in the range between 25 and 29 years, 23% is in the range between 30 and 44 years and 14% is in the range between 45 and 59 years.

Table x.6 - Age demographics

0-4	5-9	10-15	16-17	18-19	20-24	25-29	30-44	45-59	60-64	65-74	75-84	85-89	90+
9%	8%	8%	3%	3%	10%	12%	23%	14%	3%	4%	2%	1%	0%

The majority of the population in this area is married (46%), followed by single individuals (40%).

Table x.7 - Relationship status

Single	Married	Divorced	Separated	Widowed	Same Sex
13320	15165	1715	1169	1616	47
40%	46%	5%	4%	5%	0%

Apart from White (20%), Asians make up most of the population in this area, of which the largest group is Indian (21%), followed by Bangladeshi (16%) and Pakistani (14%); 45% of the population was born in England, with 48% being born outside either the United Kingdom or the European Union. Individuals born in the EU (that are not Irish) make up 6%. 63% of the population hold British passports, while 31% of the population holds foreign passports, of which Middle Eastern passports are the largest group (18%).

Table x.8 - Ethnicity makeup

White	Mixed Ethnicity	Indian	Pakistani	Bangladeshi	Chinese	Other Asian	Black African	Black Caribbean	Other Black/African/Caribbean	Other
8636	1650	9079	6139	7175	124	3045	3821	1946	817	1339
20%	4%	21%	14%	16%	0%	7%	9%	4%	2%	3%

Islam is the predominant religion in this area (43%), followed by Christianity (28%) and Hinduism (12%).

Table x.9 - Religion

Christian	No Religion	Buddhist	Hindu	Jewish	Muslim	Sikh	Other Religion	Not Stated
12335	2744	190	5060	70	18827	1843	147	2555
28%	6%	0%	12%	0%	43%	4%	0%	6%

The majority of the population has their highest qualification at GCSE level (44%), with a sizable proportion of the population holding a university degree or similar qualification (30%); 21% of the population does not have GCSEs.

Table x.10 - Highest Qualification

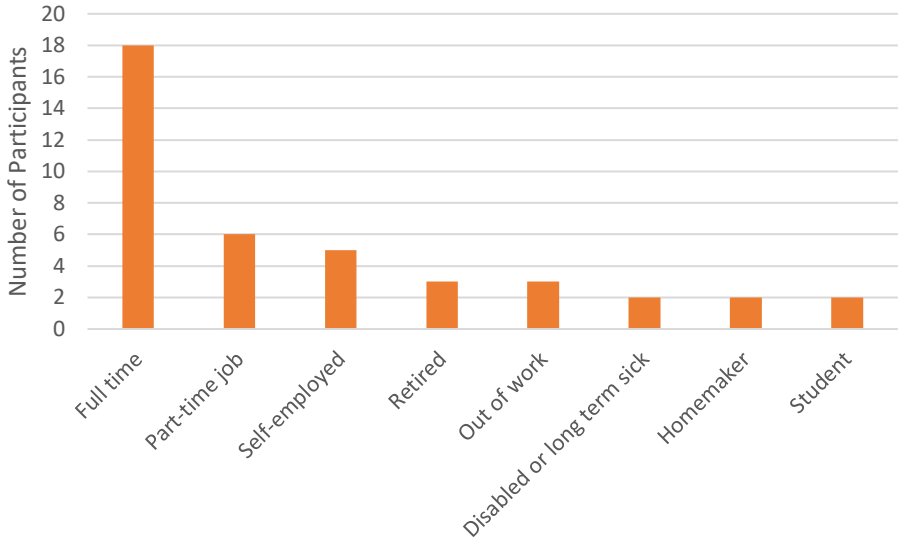
Degree or Similar e.g. professional qualification (accountancy etc)	Apprenticeship	2+ A Levels	5+ GCSEs, an A-Level or 1-2 AS Levels	1-4 GCSEs	No GCSEs	Other
9864	277	3147	3703	4107	6818	5116
30%	1%	10%	11%	12%	21%	15%

This area has a remarkably large student population (21%), followed by full-time employees (27%) and part-time employees (13%). Unemployed people make up 7% of the population. The largest employment sectors are Retail (20%), Accomodation (10%), Healthcare (10%) and Education (10%).

Table x.11 - Economic activity

Full-Time Employee	Part-Time Employee (defined as 30 hours or less per week)	Self Employed	Unemployed	Full-Time Student (with or without job)	Retired	Looking After Home or Family	Long-Term Sick or Disabled	Other
8419	3950	2591	2169	6507	2096 7	2773	1337	1672
27%	13%	8%	7%	21%	%	9%	4%	5%

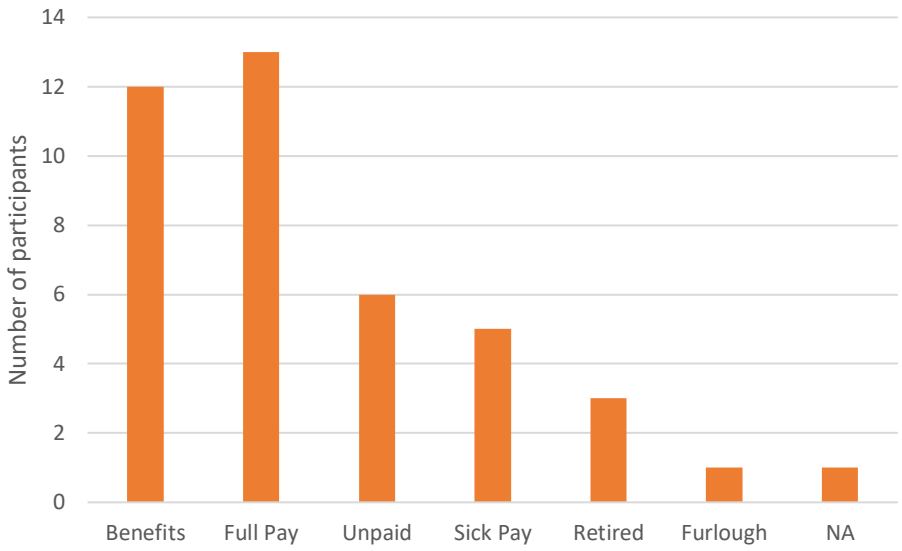
Appendix 2 Research participants COVID income source



18 research participants, representing 44% of the sample, were full-time employees. Of all full-time employees, 10 received Full Pay support, 1 participant was on furlough, 4 were receiving sick pay, 1 was receiving benefits, and 2 were unpaid. Out of the two full-time participants who were not paid, one of them was under a 0-hour contract and we can assume wasn't given hours during the period, since he was self-isolating and therefore not working. The other gave no specific explanation.

5 research participants, representing 12% of the sample, were self-employed. Out of all the self-employed participants 1 participant were getting full payment, 2 participants were receiving benefits, and 2 participants were unpaid. Out of the 2 self-employed participants who reported being unpaid, one of them stated lack of activity as the reason for being unpaid.

3 research participants, representing 7% of the sample, were retired. 2 participants, representing 5% of the sample, were students and another 2, also representing 5% of the sample, were homemakers. 3 participants, representing 7% of the sample, were unemployed and all 3 were receiving benefits. 2 participants, representing 5% of the sample, were disabled or long-term sick, of which 1 participant was receiving benefits and the other did not disclose source of income.



Overall, 12 research participants, representing 29% of the sample, were receiving benefits, 13 participants, representing 31% of the sample, were receiving full payment, 6 participants, representing 15% of the sample, were unpaid, 5 participants, representing 12% of the sample, were receiving sick pay, 3 participants, representing 7% of the sample, were retired, 1 participant, representing 2% of the sample, was on furlough and 1 participant, representing 2% of the sample, did not disclose its source of income.

Row Labels		**Count of ID**
Disabled or long-term sick		2
	Benefits	1
	NA	1
Full time		18
	Full Pay	10
	Furlough	1
	Sick Pay	4
	Unpaid	2
	Benefits	1
Homemaker		2
	Benefits	2
Out of work		3
	Benefits	3
Part-time job		6
	Benefits	3
	Full Pay	2
	Sick Pay	1
Retired		3
Self-employed		5
	Benefits	2
	Full Pay	1
	Unpaid	2
Student		2
	Unpaid	2
Grand Total		41

Appendix 3 Interview Schedule

Welfare Checks Interview WS000					
Category		**Question**	**Answer**	**Additional Comments**	**Researcher Notes**
Demographic	**1**	At what period/timeframe did you use the COVID Welfare Support Service?			*Researcher prompt: Did you contact Newham council directly looking for support or information?*
	2	What is your sex?		(Please state if other)	
	3	What is your age?			Precise number
	4	What ethnic group do you belong to?		(Please state if other)	1. White - English / Welsh / Scottish / Northern Irish / British 2. White - Irish 3. White - Gypsy or Irish Traveller 4. White - Any other White background 5. Mixed race - White and Black Caribbean 6. Mixed race - White and Black African 7. Mixed race - White and Asian 8. Mixed race - Any other mixed background 9. Asian or Asian British - Indian 10. Asian or Asian British - Pakistani 11. Asian or Asian British - Bangladeshi 12. Asian or Asian British - Chinese 13. Asian or Asian British - Any other Asian Background 14. Black or Black British - Caribbean 15. Black or Black British - African 16. Black or Black British - Any other Black background 17. Other ethnic group - Arab
	5	What is your immigration status?		(Please, state if other)	
	5.a.	Who do you live with and has anyone in your household tested positive for Coronavirus before you were tested positive?		(Please, state if other)	1. I live with my family (Parents, brothers, sisters and extended family) 2. I live with my family (Wife or husband and sons or daughters plus extended family) 3. I live in a shared property (I don't share a room) 4. I live in a shared property (I share a room) 5. Other
Testing Information	**6**	What was the main reason you got tested? What symptoms, if any, were you experiencing at the time? open question	Open question		1. High temperature? 2. A new continuous cough? 3. Loss of sense of smell or taste? 4. Shortness of breath or trouble breathing? 5. Runny or stuffy nose? 6. Muscle or body aches? 7. Headaches? 8. Sore throat?

	7	Where did you get tested?	Open question		1. At my workplace, university or care home? 2. At a local testing site (e.g. drive-through and walk-through test sites)? 3. At home, with a postal testing kit? 4. At home, with a rapid testing kit (e.g. given by my employer)? 5. Pop-up rapid testing site (received my results in 30 minutes)? 6. Mobile testing unit (e.g. a van or army-operated testing unit)? 7. By GP, in hospital, or another healthcare setting? 8. Privately tested? 9. Other? 10. Prefer not to say.
Behaviour	**8**	How long after you first started having coronavirus symptoms did you get your positive test result?			
	9	How soon after you first started having coronavirus symptoms did you start isolating?			
	10	Did you start isolating before you were contacted by Newham Covid Response or Welfare Check Team? (e.g. Distinguish call from NHS Test and Trace)			
	11	Within the first 24 hours after receiving a positive result, please tell me if you left the house for any reasons:	Open question		1. Go to the shops for groceries, toiletries or medicine or other items. 2. For outdoor recreation or exercise (e.g. a run, a walk, to sit in the park). 3. Go to your place of work, school or university. 4. To get or return a test for coronavirus. 5. For another medical reason (e.g. a doctor's appointment). 6. To help or provide care for a vulnerable person. 7. For another reason. 8. Did not leave the house. 9. Prefer not to say. You indicated you left home for another reason. Please specify the reason why you left home during this period.
	12	Please tell me how many times you left the house after receiving a positive result			Input "0" if none.
	13	On those occasions, did you wear a face mask/covering?			

	14	During that 24 hour period when you left the house, how many people did you have contact with?			By “contact” we mean either physical contact for any length of time or being less than two meters (six feet/ 3 steps) of them for at least a few minutes.
	15	Did you have any vistors come into your house during that period that were not support or care staff? If so, how long did they stay?			
	16	How many times did you use public transport after being tested positive and while self-isolating?			
THANK YOU. WE ARE ALSO INTERESTED TO KNOW WHAT HAPPENED AFTER THE FIRST 24 HOURS OF YOUR POSITIVE TEST.					
Welfare Checks	17	When you tested positive, how long did it take to receive the Newham Covid Response or Welfare Check call?			
	18	Which, if any, of the following sources provided you with guidance on self-isolating?			1. NHS Test and Protect contact tracer 2. Newham council (e.g. Newham Welfare Checks) 3. Someone at the test centre 4. Another source 5. Don’t know
	19	How clear was the guidance around self-isolation given by Newham Covid response team, where 1 is very clear 2 clear 3 not clear and 4 is not at all clear?			
	20	**Which of the following did you receive about the Newham Welfare support and isolation support service in Newham? I will read out some Statement and you can tell me by answering yes or no**			
	20. a	A supportive conversation to explore what isolation support would be helpful.			
	20. b	The positive person isolates in a hotel free of charge with food, transport to and from the hotel, medical check-ins and the option of a household member to support and care for them.			

	20. c	Household contacts of the positive perso isolate in a hotel free of charge with food and transport to and from the hotel, while the person who has COVID-19 stays in their home residence.			
	20. d	Everyone stays in the home residence with advice and support for safer isolation and COVID-19 management (welfare checks and provision of PPE)			
	20. e	Rapid tests for everyone else in the household (delivered to their home)			
	20. f	You will be able to receive regular welfare checks whislt self isolating			
	21	If you were offered hotel self-isolation then what were the reasons behind your decision to not take-up the hotel self-isolation offer?	Open question		
	22	**What feature(s) of the Newham Covid Response or welfare check call was most helpful to you? I will read out some statements and you can tell me if you 1. Strong agree 2. Agree 3. Disagree 4. Stongly disagree**			
	22.a	I was listened to by the staff regarding my needs and queries			
	22.b	The staff was polite and frindly			
	22.c	The staff made sure my needs were met			
	22.d	The staff was efficient and helpful			
	23	Did you have any challenges when self-isolating at home? If so, what were they?	Open question		
	24	Did you leave home at any point during self-isolation? For what reason? How many times?	Open question		
	25	**How was your experience self-isolating at home? I will read out some statements and you can tell me if you 1. Strong agree 2. Agree 3. Disagree 4. Stongly disagree**			

	25.a	Self-isolation has made me feel anxious			
	25.b	Self-isolation has made me feel lonely			
	25.c	Self-isolation has made me feel worried about the future			
	25.d	I felt that I was protecting my loved ones and community and that helped me to overcome the negative feelings			
	25.e	Self-isolation has made me feel worried about dying			
	26	What additional support would have enabled you to self-isolate more efficiently at home?	Open question		*Interviewer prompt: Did you get any support or help from any other local community organisations?*
	27	In your opinion, did your self-isolation help prevent further transmission of COVID in your household?			
	28	Did anyone from your household test positive for COVID in the first 10 days after you tested positive?			
	29	**Optional for interviewees who have used the hotel isolation service. Overall, how would you rate the helpfulness of the checking in phone calls from Newham Welfare Check team on a scale of 1 to 4 where 1. Strong agree 2. Agree 3. Disagree 4. Stongly disagree**			
	29.a	Newham council offered a quality service regarding self isolation			
	29.b	Hotel accomodation was able to fulfill my needs			
	29.c	It was easy for me to have my worries known by the council			
	29.d	Hotel service was not suitable/needed			
	30	**Before being contacted by the Welfare Check Team, were you aware of the different types of support Newham Council offered?**			
	30.a	Financial advice and support			
	30.b	Newham Stay Home Support Payment or Microgrants			

	30..c	Someone to talk to by connecting them with Connect Newham (befriending service)			
	30.d	Food support including help with online shopping or referral to the "Newham Food Alliance"			
	30.e	Support accessing medicines with referral to NHS Volunteers			
	30.e	Somewhere to isolate safely using Newham Hotel Isolation Programme			
	30.f	Advice about your health (when to call 111 or 999)			
This next set of questions are about your understanding and experience of isolation, and your feelings about coronavirus and the Local Government's response.					
Knowledge of Self-Isolation	**31**	Before you found out about the Newham welfare support service / COVID response service, how were you going to financially support yourself whilst self-isolating?	Open question		
	32	**This next set of questions are about your understanding and experience of self-isolation, and your feelings about coronavirus and the Local Government's response.** **I'm now going to read out some statements to you and would like you to answer with:** **1. Strongly Agree** **2. Agree** **3. Disagree** **4. Strongly Disagree** **5. Don't Know** **6. Prefer Not To Answer**			
	32.a	It is important for me to follow the self isolation advice			
	32.b	It was easy for me to self isolate			
	32.c	I support the legal requirement to isolate			
	32.d	I support the legal enforcement of compliance to self isolation guidelines			
	32.e	I think we should leave self isolation guidelines to individual responsibility			

	32.f	The government is putting the right measures in place to protect the public			
	32.g	Information from the government about coronavirus can be trusted			
	32.h	I think the government is flawed, but doesn't act maliciously	3. Disagree		
	32.i	Politicians cannot really be trusted			
	33	**Please let me know which of these statements are true.**			
	33.a	You should self-isolate for 10 full days if you've tested positive for coronavirus (COVID-19).			
	33.b	If you've been in close contact with someone who has COVID-19, you may have to self-isolate for 10 full days.			
	33.c	You might need to self-isolate for longer if you get symptoms while self-isolating or your symptoms do not go away.			
	33.d	Vaccination can help protect you from contracting Cornona virus			

Employment or Benefits	**34**	**What best describes your work situation when you received your positive test?**		Were you in ... 1. Full-time paid job? (31+ hours) 2. Part-time paid job? (1 - 30 hours) 3. Furlough? 4. Self-employed? 5. Receiving statutory sick pay? 6. Student or on government training programme? 7. Retired? 8. Disabled or long-term sick? 9. Unpaid work for a business, community or voluntary? 10. Looking after home and family or Homemaker? 11 Out of work	*Researcher prompt : How would you describe your financial situation during lockdown? Would you say you were living comfortably or struggling with finances?*
	35	During your self-isolation, how were you paid?		(Please state if other)	
	36	Are/were you a key worker?			
	37	Which category of key worker do you fall into?		1. NHS / health care 2. Social care 3. Public safety and national security (Police, Fire, Counter Terrorism, Military, Border Security, Prison, Probation) 4. Education and childcare (teaching and support staff, nursery workers, childminders, SEN worker) 5. Local or national government 6. Public services (justice system, religious staff, frontline charity, journalist, funeral staff) 7. Food or other necessary goods (sales, delivery, production, processing) 8. Transport 9. Utilities, communication and financial services 10. Other	
	38	Have you received any payment through the Coronavirus Job Retention or Furlough scheme?			

	39	Do you currently claim any State Benefits or Tax Credits (including State Pension, Allowances, or National Insurance Credits)?			
	39.a	**If so, which of the following do you receive?**	**Received**		
	39.b	Universal Credit.			
	39.c	Housing Benefit.			
	39.d	Council Tax Reduction.			
	39.e	Tax credits.			
	39.f	Job Seeker's Allowance (including National Insurance Credits).			
	39.g	Personal Independence Payment.			
	39.h	Employment and Support Allowance.			
	39.i	Other sickness or disability benefits.			
	39.j	Pension benefits (including state pension or pension credit).			
	39.k	Other benefits from your Local Authority.		(Please state here)	
	39.l	Other		(Please state here)	*Researcher prompt: Did you apply for a Self-Isolation Welfare Grant, or had one applied on your behalf? Was your application successful?)*
Health & Wellbeing	**40**	How do you feel about your health and wellbeing after self-isolating?	Open question		*Researcher prompts: Do you think your mental health has become better or worse after the experience? Do you think it is related to the experience? If so, in which manner?*
Trust	**41**	How has your perception of the Council changed since engaging with the Welfare support service? What changed? Why?	Open question		
	42	**In what way has your 'trust' in the council changed since you used the service? I will read out some statements and you can tell me if you 1. Strong agree 2. Agree 3. Disagree 4. Stongly disagree**			
	42.a	My experience through Welfare service has positively changed my views on the council			

	42.b	I think some groups have more rights than others when receiving council services			
	42.b	In general, the council has been efficient and effective in managing this situation			
	43.c	I have always had a bad impression of the council			
	44	How would you rate your overall experience of the Welfare Support Service?			
	44.a	I wish the council had given me more information on the offered services			
	44.b	In comparison with what I have been offered, the resulting service has been poor			
		Additional Comments (e.g. Is there anything else you would like to tell about your experience of the Welfare Check call(s) and Welfare Support Service?) PLEASE CONFIRM FOR ME YOUR ADDRESS IN ORDER TO POST YOUR 10 VOUCHER	(Insert any additional comments here)		