University of East London

Newham London

COViD-19

Response and recovery in the London Borough of Newham
Prepared by Dr Darren Sharpe
The Institute for Connected Communities (ICC)

FOREWORD 1

COVID-19 was unprecedented. It hit very hard in Newham. A particularly risky mix of many people with front line jobs, living in mixed age and often crowded households, limited space, high levels of health issues already and high levels of deprivation meant that we had one of the worst rates of death in the country. And yet, as this report goes on to show, we also had some of the most innovative, collaborative and collective responses to what was happening. Our COVID-19 Champions programme was groundbreaking and it led to national adoption and more than £50m in funding from central government to local places. We were the first place in the country to have walk-in testing; our family vaccination clinics meant people came with their children and their parents to get the life-saving vaccine. More than 15 local organisations hosted vaccine clinics, which meant people got to go somewhere they felt comfortable to have a jab, which for some was quite a frightening thing to do. Our Help Newham programme, launched by Newham Council during the COVID-19 pandemic, supported around 27,000 vulnerable residents with essential services, delivering over 10,000 meals per week to those in need, including the elderly, disabled, and shielding individuals.

While for some COVID seems a hazy strange memory, for many of us it leaves a painful legacy of people who are no longer with us, of lives we used to lead and ways we used to be. And yet, it has also taught us – as local leaders – so much about the way we can and should work with academics like Professor Winston Morgan and Dr Darren Sharpe, with clinicians like Dr Wax Naqvi and Dr Vanessa Apea, and most importantly, with communities and community organisations. The generosity, energy, directness and kindness with which communities and community groups came together is remarkable. We are keeping that going, whether to address the on-going financial pressures we all face, responding to the incredibly high rates of poor mental health, particularly in children and young people, or doing all we can to respond to and live in a changing climate.

This monograph is one of many powerful resources we will use to continue our work with everyone who lives in and cares about Newham, and we welcome the insights and lessons within it.

Anne Pordes Bowers
Community Public Health
London Borough of Newham

Jason Strelitz
Director of Public Health
London Borough of Newham

FOREWORD 2

As the pandemic took hold, and data from the Office for National Statistics began to show that people from certain racial and ethnic groups were disproportionately affected in terms of infection and death, a narrative began to appear that suggested a genetic link between a person's race and their susceptibility to the virus. As a senior Black scientist, I noticed that at no level from the Chief Scientific Officer down was this misconception being effectively challenged. I started writing articles and opinion pieces arguing that this phenomenon was more about sociology and structural racism than it was about biology. This was picked up by colleagues in the Newham Public Health team, who invited me to join their team of experts at public engagement events to talk about how the virus worked, then, later, as the vaccine was being developed, how a vaccine would protect the individual and the wider community. I also used my knowledge of toxicology and pharmacology to explain how a vaccine could be developed so quickly and safely. Throughout, the focus was to enable the public to make an informed choice. At the height of the pandemic, the public meetings were biweekly. The meetings were mainly online with specific community groups, including faith groups, care homes, schools/colleges and the general public. Given that the impact of the virus was racialised from the start, it was important for professionals from the different racialised communities to be represented in these public events, as one of the key lessons of the pandemic was that the messenger was as important as the message.

Professor Winston Morgan BSc, PhD, FHEA, FRSB
Professor of Toxicology, Equity and Inclusive Practice
School of Health Sport and Bioscience,

FOREWORD 3

As the UK experienced the first wave of COVID-19, the University of East London sought to work in partnership to respond to the disproportionate impacts being experienced by our local communities. Working with Newham Public Health and local voluntary, community and faith sector networks to share information, knowledge and skills, we sought to respond to the specific challenges faced by communities and service providers in this rapidly evolving environment. The themes articulated in this monograph of unequal impacts, trust, access, public health messaging and wider content that is created with communities, and of diverse communities being seen and heard, are significant for the development of future health initiatives and services.

Gail May
Director of the Office for Postgraduates
Research and Engagement at the University of East London

CONTENTS

1.INTRODUCTION

This monograph details the efforts to respond to, and recover from, the COVID-19 pandemic in the London Borough of Newham, based on research carried out by the University of East London (UEL). It discusses several specific strategies to contain the spread of the virus and to support residents during this difficult time (e.g. Welfare Check-in phone calls and the Hotel Isolation service). It presents an overview of the challenges and legacy of COVID-19 in the Borough, and of the work delivered in response, and it provides insights and recommendations of relevance for responding to any future pandemic, as well as for other health initiatives.

The pandemic exacerbated existing inequalities and restricted opportunities in terms of education and employment. The monograph focuses, in particular, on the disparity of impact, both of the disease itself and of the steps taken to restrict transmission (e.g. lockdowns), in terms of ethnicity, age, socioeconomic group and pre-existing physical and mental health conditions, as well as considering issues of trust and mistrust among Newham residents regarding various sources of information, which is particularly significant for the uptake of vaccinations.

1.1 COVID-19

In January 2020, the World Health Organization (WHO) first identified the strain of coronavirus that causes the respiratory illness COVID-19, and in March 2020, it declared COVID-19 to be a global pandemic. Subsequently, many countries imposed nationwide or localised lockdowns to reduce transmission of COVID, closing schools, universities and workplaces, leaving students to learn remotely, enforcing social distancing orders, and implementing restrictive measures that prevented individuals from going to public places and meeting people from other households.

Quarantines and lockdowns are states of isolation that are psychologically distressing and economically challenging for anyone who experiences them (Brooks et al., 2020), and especially so for those who are clinically vulnerable, in insecure employment or socially marginalised. The pandemic had a disproportionately negative impact on communities who often face multiple barriers to services and support, as well as societal disadvantages, such as people from black and minority ethnic backgrounds, people of sexual/gender minorities (LGBTQ+: lesbian, gay, bisexual, transgender, non-binary, intersex and queer), and people living with physical and learning disabilities.

1.2 THE LONDON BOROUGH OF NEWHAM

DEMOGRAPHICS

73% of Newham residents are from black, Asian and minority Ethnic groups (BAME)

57% do not have English as a first language

Over ⅓ are under the age of 25

37% adults and half of all children live in poverty

The London Borough of Newham is ethnically diverse. Of its 360,000 residents, 73% are black, Asian and from minority ethnic groups (BAME); 57% do not have English as a first language, with a reported 200 languages spoken. It also has one of the youngest populations in the UK, with over one third of residents under 25 (ONS, 2022).

The Borough is also within the most deprived 10% of local authorities in England. Fewer than 5% of the Borough Lower Super Output Areas (LSOAs) are in Index of Multiple Deprivation deciles higher than the median decile. Work is highly mobile, marginal and poorly paid (median income £28,000), with over-representation of 'gig economy' roles. An estimated 10,000 people have no recourse to

public funds. While race and ethnicity play a part, Newham residents face many other realities which impact their health. Up to 37% of residents, and half of all children, live in poverty, and more children live in temporary accommodation than anywhere else in London (1 in 12) (MHCLG, 2019).

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 (PHE) 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. 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. Attitudes towards vaccination take-up can be used as a proxy for trust in scientific knowledge, political agents and agencies.

Newham had one of the worst standardised mortality rates in England, with more than 783 reported deaths with COVID-19. Factors that contributed to this included increased exposure and severity of outcomes. For example, many residents work in people-facing jobs, are self-employed or have insecure employment – health, social care, retail, transport, security. Newham has the most overcrowded households in London, significant numbers of houses in multiple occupation, and high numbers of multigenerational households. High levels of health risks are linked to ethnicity (e.g. diabetes, cardiovascular diseases, obesity). It was anticipated that many residents would experience significant barriers to vaccine uptake, ranging from the structural (non-registration with GP, distance to vaccine site) to the cognitive (the language in which information is presented, and fear as hesitancy – fear of experimentation or side effects, fear of repercussions of engagement with statutory agencies, and fear of loss of employment) and social (membership of misinformation-sharing networks). The Council was committed to addressing these as part of the Well Newham community partnership, and 50 Steps to a Healthier Borough, the 2020–23 Newham Health and Wellbeing Board strategy.

During the pandemic, the Public Health Team in Newham worked with partners via Well Newham to address inequalities and develop programmes with champions, the voluntary, community and faith sector, and NHS partners to address the health issues associated with these inequalities.

2. TEST, TRACE AND ISOLATE (TTI)

Research carried out in December 2020 revealed Newham residents' test, trace and isolate journeys, and what helped them to better self-isolate to reduce the spread of COVID-19, as well as the challenges they faced. This section highlights which issues mattered most to different groups of residents, particularly in terms of protected characteristics.

Issues within the Council's control were: reducing waiting times for test results; continued contact with doctors and primary care; provision of more information, and of translations and translators to answer questions; financial support; job protection; preventing loneliness; housing protection in flat-shares; the impact of isolation on wellbeing; GP delivery of Test

and Trace; and stigma associated with testing positive. Other Issues could be lobbied about, but could not be directly controlled, including: space/facilities for a family to isolate within a household; couples forced to isolate apart; and people isolating without adequate resources.

The two issues most reported by participants were the need for guarantees that they would not lose their job (76%), and the need for help with shopping and other essential tasks (73%). People also referred to the need for more money (44%), childcare support (43%) and wanting someone to talk to about their worries (40%), among other things.

Those aged 19–30 were most concerned about job insecurity (86% were concerned). Of the self-employed, 83% had this concern, as did 72% in full-time employment. Of those with mixed ethnic background, 90% were worried about their job.

Those aged 61–70 were most concerned about help with shopping and other essential tasks (93%). Of those working part-time, 91% had this concern. Those in households of 1–2 or 5–9 people were most likely to express this (both 78%).

Those most concerned about childcare or other caring responsibilities were homemakers (61%), white (63%) and black (63%) respondents, and those in households of 1–2 (49%) or 5–9 people (78%).

Of male respondents, 56% could not get sick pay; 53% of female respondents had this problem. This was a problem for 60% of respondents who were living with a disability. Of those from mixed/multiple ethnic backgrounds, 70% could not get sick pay; the problem was experienced by 65% of white, 53% of black/African/Caribbean/black British, and 36% of Asian/Asian British respondents. Across socioeconomic groups, 58% of full-time self-employed, 56% of full-time employed, 50% of unwaged, and 42% of part-time furloughed respondents reported it.

Comparing the Tier 4 survey (a data collection process associated with the UK Visas and Immigration system for monitoring international students who are in the UK under a Tier 4 visa) with the Lockdown 3 survey (the third lockdown in England began on 6 January 2021), regarding what would help people to better self-isolate, the need for help with shopping and the need for more money increased, the need for a guarantee that they would not lose their job decreased, as did the need for childcare support and the desire for shorter isolation times, and the need for somebody to talk to about worries remained the same.

3. REASONS FOR TRUST AND MISTRUST

The decline in trust in politicians and political institutions in the UK is well-researched. Trust in scientists and scientific institutions has also declined. The democratisation of information and the rise of social media have contributed to this, and have also created 'echo chambers', spread misinformation and conspiracy theories, and caused information overload. These factors eroded public trust in information about COVID-19, and in government measures to tackle the pandemic. Research carried out in February 2021 revealed the degree of trust in various sources of information about COVID among residents in Newham.

3.1 WHO DID RESIDENTS TRUST THE MOST?

Respondents were asked, 'Who do you trust the most to give you information about COVID-19 test, trace and isolate pathways?' From 129 responses, the most trusted sources of information were Public Health England (56% trusted this source), GPs (54%), the local public health team (45%) and Newham Council (39%).

Female and male respondents trusted Public Health England fairly equally (57% and 55%, respectively). The age groups that most trusted PHE were 19–30 (67%) and 51–60 (65%). Full-time self-employed and part-time self-employed furloughed respondents trusted PHE the most (both 67%). Respondents of mixed/multiple ethnic background (80%) and white respondents (63%) trusted PHE the most.

WHO DO YOU TRUST THE MOST?

56% trusted Public Health England

54% trusted GPs

45% trusted local public health team

39% trusted Newham Council

More females (60%) than males (44%) trusted their GP. Ages 41–50 (65%) and 51–60 (60%) trusted their GP the most, as did white (63%) and self-employed people (63%).

Females and males trusted the local public health team fairly equally (46% and 44%, respectively). The 'other' ethnic group (67%), black (58%) and white (57%) respondents, and those of mixed/multiple ethnic background (50%) most trusted the public health team. Ages 71–80 (75%) and 31–40 (56%) most trusted the team. Those in full-time employment (56%) and full-time self-employment (52%) most trusted the team.

Male respondents trusted Newham Council more than female respondents (42% and 37%). The age groups that most trusted the Council were 31–40 (48%) and 41–50 (47%). Those of mixed/multiple ethnic background (50%) most trusted the Council. Part-time furloughed respondents trusted the Council most (50%) among socioeconomic groups.

Some ways to maintain and build trust are: use trusted individuals to communicate; use community-based networks; ensure a confidential process; clear, consistent messaging from central government; provide more information about why TTI is important, even if someone does not feel unwell; use celebrities for messaging; and provide credible, verifiable scientific evidence for a 14-day isolation period.

3.2 WHO DID RESIDENTS TRUST THE LEAST?

In focus groups and responses to open questions, participants frequently reported mistrust and fear as barriers to using TTI, defined by participants as resulting from confusion, contradictory advice, inaccessible or inadequate help or advice, dysfunctional systems and frightening statistics.

Residents were asked who they trusted least to give information on TTI. From 129 responses, the least trusted sources of information were: social media (43%), the government (35%), neighbours (28%) and faith leaders (21%).

Male and female respondents equally distrusted social media (44%). The age groups that most distrusted social media were under 18 (75%) and 61–70 (63%). White (52%) and black (47%) respondents most distrusted social media. Part-time furloughed (58%) and waged full-time (58%) respondents distrusted social media equally.

Female and male respondents equally distrusted the government (40%). Age groups that most distrusted the government were under 18 (50%), 71–80 (50%) and 19–30 (47%). Of those living with a disability, 47% distrusted the government. Of white respondents, 50% distrusted the government. The socioeconomic groups which most distrusted the government were full-time self-employed (42%), part-time furloughed (42%) and unwaged – retired, student, homemaker (41%).

Of male respondents, 29% did not trust their neighbours regarding information about COVID; 27% of female respondents felt this. Those of 'other' ethnic background (50%) and those of multiple/mixed ethnic background (40%) were the groups that moat distrusted neighbours in this respect. Under 18s (50%) and ages 31–40 (33%) most distrusted neighbours. The full-time employed and the part-time furloughed most distrusted neighbours (39% and 33%, respectively).

Of male respondents, 27% did not trust their faith leader for information about COVID; 15% of female respondents felt this. Ages 51–60 (30%) and 31–40 (26%) distrusted faith leaders the most. Those of mixed/multiple ethnic background most distrusted faith leaders (30%). Part-time furloughed respondents most distrusted faith leaders (42%).

Reasons why trust was lost included:

Mistrust of government's interpretation of scientific evidence	Concern about a non-confidential service	Fear of the involvement of authority, such as police and immigration officers
Concerns about vaccine safety, and about the expedited service	Reduced perceived risk, especially among those who had already had COVID	Concerns about government transparency

3.3 COVID-19 CHAMPIONS' PERCEPTIONS OF COVID-19 VACCINATION

It is important to tackle mistrust in public institutions, misinformation, information overload, and untailored information about COVID-19. BAME groups have long experienced poor healthcare compared to their white counterparts, and the testing, manufacturing and administration of the COVID-19 vaccines occurred against the background of the Black Lives Matter movement, which exacerbated the 'unconscious' and 'conscious' fears of black residents about taking a rapidly developed drug. Understanding the barriers and drivers to vaccination take-up is necessary to protect individuals and communities in Newham, and to ensure that community members and social care practitioners can shape messaging to reach out and promote vaccination take-up rates of BAME residents and social care workers in Newham.

COVID-19 champions said that they needed a number of things to increase their confidence in available vaccines. They needed factual/authoritative and digestible information to share with family, friends and community. People were afraid of being vaccinated, so clear information was important. Sometimes fear stems from real threats, but it can also originate from imagined dangers. COVID champions also needed information about the ethnicities/'race' of groups that the vaccine had been tested on, because fear could be based on 'perceived' and 'real' cases of drugs being tested on BAME communities by white scientists. While faith leaders stressed the priority of saving lives, champions also

needed facts about the ingredients of the vaccines (e.g. pork, egg). They needed reassurance about the expedited manufacturing process for a new vaccine – how did scientists/government save so much time in the development of the vaccine, while ensuring that it was safe? They needed reassurance about people's entitlement to receive a vaccination, and especially about vaccine access for people fearing identification by the authorities, for example, due to their immigration status. They also needed information about correct dosage and sequence of vaccinations, in the context of mixed messaging regarding half and full doses relating to the Oxford/AstraZeneca vaccines, and about the possible short- and long-term adverse effects of vaccination, as well as about access points for vaccination.

3.4 SOCIAL WORKERS' ROLE DURING THE PANDEMIC

Social workers were asked what would make them feel more comfortable in their role during the pandemic. They wanted easy access to testing, with priority given to frontline staff, rather than having to queue and to book ahead. Social workers experienced increased stress at work during the pandemic, and they often felt helpless, and not valued. They were concerned about going back to their families, not being sure if they had caught COVID after close contact, possibly with someone who was asymptomatic. They felt that they were not given high-quality PPE; even if they had gloves, apron, mask etc., they could not be sure that they were wearing and removing it properly. They also felt that the social value of social work was not recognised.

Social workers raised various critical issues. Injustice in the system cannot be addressed without involving partners (e.g. housing teams) – a whole system approach is needed. The track and trace system was dependent on owning a smartphone, but many customers did not use a smartphone. More support and detailed information were needed by occupational health – beyond risk assessments – in the care of BAME social workers. Having the facts about COVID and vaccinations was critical, because social workers' fears and concerns about vaccination take-up could be transmitted to customers. Up-to-date financial aid information (e.g. benefits and entitlements) was needed to share with customers during the pandemic.

4. WELFARE CHECK-IN CALLS

4.1 BACKGROUND

The Newham Welfare Check-in phone call was delivered by the COVID-19 Response Team (CRT), to help residents to self-isolate better, and to provide them with COVID-related advice, support and benefits. It was piloted by the Council to help residents who tested positive by using a resident-centred approach, emphasising supportive conversations, meaning that residents were offered the advice, help and benefits they wanted, focused on what mattered to them, rather than on what the call handler thought was important.

The pilot ran from March 2021 to November 2022. The problems that the Council expected to address were: 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 medical help. The aims were: to have supportive conversations with residents; to provide advice and connect them to support to isolate; to build trust with residents, and better foundations for future engagement, demonstrating that local authorities have residents' best interests at heart; and to increase compliance with isolation, and prevent transmission of COVID.

The calls involved, as required: Welfare Checks; contact tracing; shielding calls; the Hotel Isolation offer (see below); and vaccination bookings. From December 2020, welfare checks were delivered to residents aged 60+ who had tested positive for COVID; from February 2021, they were delivered to all those who tested positive. Support offers were set up during the first wave – befriending, Newham Food Alliance etc.

4.2 EVALUATION

In September 2021, the Institute for Connected Communities (ICC) based at the University of East London (UEL) was appointed by Newham Council to undertake an independent evaluation of the Welfare Check-in call offer. Using semi-structured telephone interviews – combined with held data – accounts of 41 adults who used the service between May and November 2021 were collected and thematically analysed. Participants were males and females, aged 20 to 75+, from BAME groups and white British, UK nationals and non-nationals. The average profile was aged 20 to 25 and a naturalised British citizen, reflecting the national picture of COVID benefit claimants (Edmiston et al., 2020), and the demographic characteristics of Newham. All had tested positive for COVID; at the time of the interviews, all had recovered.

The most common issues reported during isolation were:

Loneliness, anxiety or boredom 11 respondents (27%)	COVID-19 symptoms, such as temperature, weakness or numb senses, 6 respondents (15%)	Need for assistance (groceries, day-to-day maintenance activities or childcare) 3 respondents (7%)
Financial struggles 17 respondents (41%)	Did not report any challenge or did not answer the question 4 respondents (10%)	
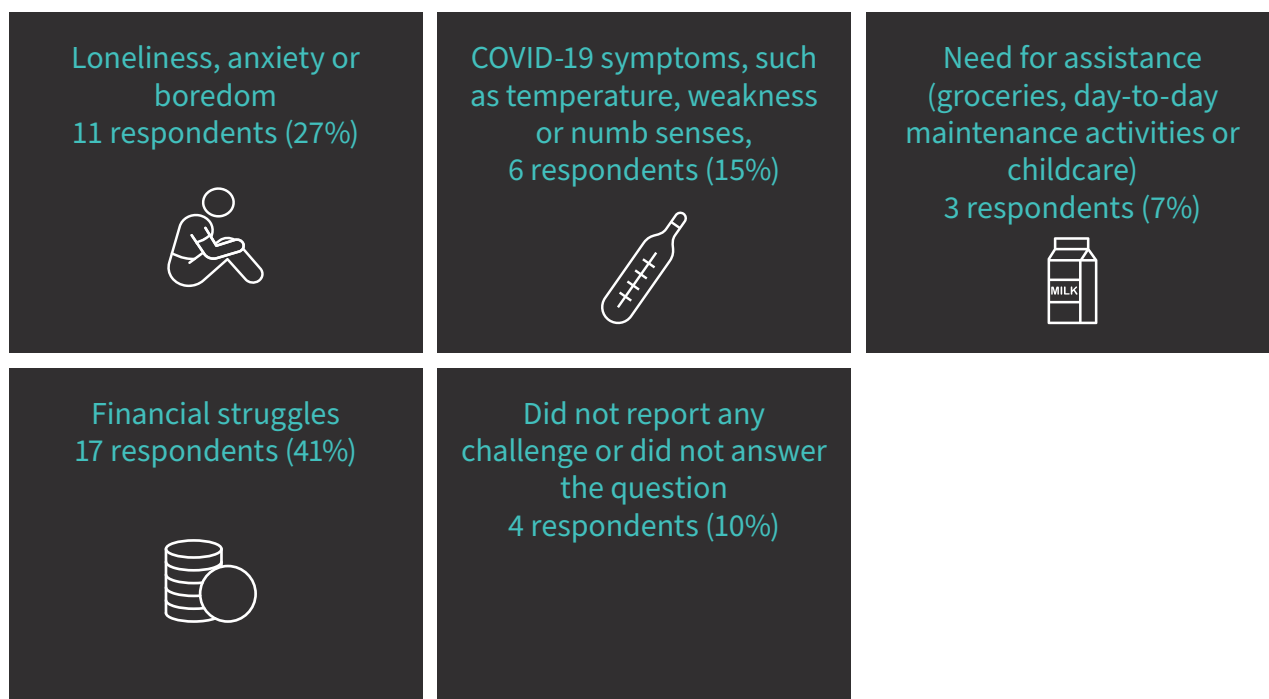
Participants were more likely to start isolating within 24 hours than they were to get tested in that period. In other words, most started to isolate – adhering to government guidance – before being tested. Most started isolating within 24 hours, with the number that isolated decreasing over time, while testing, although still concentrated within the first 24 hours, decreased much more slowly, suggesting that people might delay testing more than isolation. Of participants, 11 (27%) reported that household members tested positive in the 10 days after they tested positive.

The small sample means that recall bias is likely – first, due to the inability of some participants to accurately recall events surrounding the call due to COVID symptoms, and second, being engaged citizens with a positive view of the Council. It was not possible to recruit a representative number of 18–19-year-olds from the pilot programme, mainly due to disconnected mobile phone numbers.

The profile of participants aware of financial support was more female than male, aged 21–25 and Asian, predominantly of Indian descent. The profile aware of microgrants was female, aged 21–25, of either Asian or Pakistani descent, or white of non-British descent. The profile aware of befriending support was female Asian (no predominant descent) or white British, aged 16–85. The profile aware of the food support service was male, aged 21–25 and Asian (of Indian and Pakistani descent) or black (no predominant descent). The profile aware of medicine access support was even in terms of gender, and evenly distributed among age groups, but with more frequency in ages 36–40, and Asian, predominantly of Pakistani descent. The profile aware of self-isolation support was predominantly female, aged 21–25, and Asian or black (no predominant descent). The profile aware of health advice was female, aged 21–25 and Asian, of Bangladeshi or Indian descent, or black of African descent, or white of non-British descent.

4.3 WHAT WORKED WELL

Access, information and quality of the Check-in calls were effective overall in addressing physical, emotional and social wellbeing needs to isolate better and reinforce family resilience. Participants were highly appreciative of the supportive conversations, especially in helping them to find practical solutions to isolating problems. Most (24) acknowledged and enjoyed the conversation; 17 reported getting advice and support; 3 asked for fewer calls. The calls helped most, if not all, to isolate.

Participants most valued: receiving inbound calls (as texts and emails were often missed); consistency of call handlers; polite and friendly call handlers; a clearly communicated introduction to the service, tailored to age and language spoken (including Hindi, Bengali, Romanian, Urdu and Spanish); timely calls when help was needed; streamlining calls to multi-case households; an empathetic call handler, willing to deviate from the script; and being able to build COVID-19 health literacy.

The calls were considered good in terms of speed of response (less so in terms of reliability). Most were contacted within two days of testing positive, while a few were only contacted at the end of isolation. Participants were signposted to community services, such as food deliveries. As many were suffering boredom, they were grateful for a compassionate, motivational conversation, even when they did not request further help. This was of immense value in overcoming feelings of loneliness and low-level depression. The calls also helped some to overcome fear of death from the virus.

Call handlers were seen as a good representation of the Council, being a channel for residents to communicate concerns. The calls created good will between participants and the Council, nudging trust upwards. This was reflected across generations, gender and ethnicity, and it was demonstrated by continued engagement with the service.

There was a moderate level of transmission within participants' households during the period of the calls. However, there was also an increase in COVID health literacy. Participants did not passively take part in supportive conversations. Power differentials between call handler and participant existed, especially as the calls were inbound, and the participant had no control over if or when they received their first call. 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 about what they expect to gain in such exchanges. However, dependency relationships did not develop between call handers and participants, which helps to explain how and why participants felt both gratitude and dissatisfaction with different aspects of the calls.

4.4 WHAT WORKED LESS WELL

Participants stressed that they could have more effectively engaged in conversations if they had been given more information about the services/resources open to them. They reported withholding information because of lack of knowledge about the scope of the call. They would also have liked less scripted, more empathetic, calls.

Information was given orally by the call handler, but participants' accounts suggest inconsistency in sharing information. Some were unable to absorb oral information, especially those from black and ethnic minority communities for whom English is not their first language, and due to their symptoms. Given that participants were responsible for identifying their own needs, information about services and resources could have been shared better by providing printed material in appropriate languages. This would also have enabled them to share information with their family (including older relatives), lessening the burden of decision making.

Participants suggested that call handlers should have tried to gather more insight into household size and circumstances, to jointly identify which services/resources were needed most. Combined with a consistent call handler, this would have helped participants to manage

calls alongside household responsibilities. They reported 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). They were sometimes asked to consider the needs of up to five household members in a single call (or in separate calls), which a few struggled to do. It was difficult to absorb all the information within a highly pressured home environment. Engaging through one family member did not always guarantee that the right information reached the right person, and that the right need was elicited.

Participants would also have liked better coordination of timing and frequency of calls; sometimes, different team members called several times in one day. One participant said that he was tired of long calls for his five family members, when his pregnant wife was very unwell, and he needed to attend to his young children. Some participants found conversations challenging while experiencing breathing problems or needing rest due to COVID, and they felt that calls were too long. In contrast, some who answered calls on behalf of family and who later tested positive said they felt neglected when they did not receive a call about themselves. A few only received a call at the end of isolation, so they could not take advantage of much-needed help.

Participants shared why they did not accept additional support when it was offered (beyond isolation advice in the call): a few had resources to see them through isolation (e.g. sick-pay, savings); others had support networks (e.g. WhatsApp groups, mosque). Unbeknown to call handlers, a minority felt pressured by family members, and by their faith and culture, not to accept external help. This was not intimidation; it was driven by a need to protect loved ones, and to prevent family separation. Peer pressure was an internal/external regulation device not to break religious, cultural and family rules, and a normative standard about accepting help from outside familiar networks. They were happy to accept help from extended family and communities, but not from unfamiliar or unsolicited individuals or organisations. On rare occasions, they suggested that they were told to limit their engagement with the calls (e.g. in a multi-occupancy household for single men or low wage earners), out of fear that sharing personal information would negatively impact the family or livelihoods of other occupants.

Participants reported that Welfare Checks and advice and support were the issues most discussed, while Hotel Isolation, isolation help for household members or provision of rapid tests were commonly reported as not discussed.

Of participants, 6 (15%) needed support for household chores, groceries and other day-to-day activities disrupted by isolation; 5 (12%) suggested more financial support for those whose personal economies were disrupted; around 7% suggested other support initiatives, such as medical support or non-English-language information, specifically for Asian languages such as Urdu or Tamil. Some noted that call handlers were not trained to offer more support with COVID health literacy. One asked for fewer calls.

There was a gap in provision for participants with complex health and social care needs – e.g. childcare responsibilities, dementia and autism – who struggled to access the right support to

isolate better. For them, the supportive conversations did not always lead to the right provision at the right time. For some, it seems that there was need of a plan for follow-up, or that more could have been done to ensure that needed support was provided (e.g. food, talking therapy, language support).

Areas that could have been improved include building collective action to ensure a unified approach across the CRT, and ensuring that residents are aware of support services available via targeted leafleting, the Council website, social media and local publications. However, the small team was assembled quickly using redeployed staff in response to the emergency. While other COVID-19 Check-in call models exist, providing health and wellbeing support to the homeless or students, delivered by peer advocates or care navigators, there are no benchmarks for evaluating supportive conversations as part of such calls during a pandemic.

5. HOTEL ISOLATION

5.1 BACKGROUND

Just one in eight people in the UK lives alone, according to the Office for National Statistics. Within-household transmission is 'very common', according to the Scientific Pandemic Influenza Group on Modelling (Pagel, 2021), which advises the UK government, but it can be mitigated in part by offering information and support.

The Hotel Isolation service was a piloted strategy to aid self-isolation, targeted at COVID-positive residents, and those who might have been exposed to the virus. It provided free accommodation to help reduce transmission within households, thereby reducing spread within the community. The pilot ran from 1 March to 30 November 2021. This was not the same as the Hotel Quarantine scheme for nationals returning to the UK; it was for residents who could not adequately isolate at 'home'. Hotel Isolation also provided practical assistance to individuals who were homeless and 'sofa surfing'. While the Council did not have a plan or dedicated resources for such an unpredictable global event, they were agile and creative in finding solutions to implement Hotel Isolation against the backdrop of fast-changing national guidance on isolation.

In this section, there is a distinction between the 'service' and the 'facilities': the 'service' refers to the package of help and guidance given to residents, whereas the 'facilities' refers to the actual accommodation.

5.2 EVALUATION

Newham Council commissioned the ICC to undertake an independent evaluation of the Hotel Isolation strategy between September and December 2021. Qualitative telephone interviews explored the perceptions of guests: 10 COVID-positive cases and 2 household contacts who had accepted Hotel Isolation were interviewed, as well as 2 further cases (1 COVID-positive and 1 household) who had declined the service.

The participants were aged 25–58, drawn from the Hotel Isolation register, reflecting diversity of gender, age, ethnicity, health and social care needs. The sample was over two third males. Of participants, 3 were white British, 4 were white 'other' (Bulgarian, Portuguese, Moldovan, Turkish), 4 were black African or Caribbean, 1 was British Indian and 2 were Asian Indian living in the UK on work or student visas.

Participants reported mixed experiences of Hotel Isolation from positive or benign, through to distressing. Most reported situational social alienation, anxiety and depression. Most described isolating in a hotel as fairly helpful (3 individuals, 21% of the sample) or very helpful (9, 64%) in stopping the spread of COVID. Most described the service provided by the Council (including Welfare Checks) as fairly helpful (3, 21%) or very helpful (8, 57%). Half (7) had planned to isolate at home, and half (7) reported negative effects of Hotel Isolation. Of participants, 57% (8) said that their perception of the Council had improved compared to their previous perception; 21% (3) said that their perception had worsened; 57% (8) suggested that their trust in the Council had improved. All levels of compliance, trust and awareness around COVID improved over time, with downturns around April and July 2022. The central motivation behind willingness to engage in the service was to keep family members safe.

5.3 WHAT WORKED WELL

A high proportion completed isolation at the hotel, suggesting a high level of acceptability. The service supported the effectiveness of the local COVID TTI system.

Trust in the Council increased, hinging on gaining access to the free facility that helped isolation, and on the supplementary support (e.g. health literacy information, taxis, food parcels, bedding, testing regime and Welfare Check-in calls). This was underpinned by an appropriately pitched and agile service provided by the CRT, finding solutions to enable residents to effectively isolate despite changing circumstances.

For participants, the benefits were in keeping friends and loved ones safe. Most were living in overcrowded accommodation, sharing facilities with four to seven households. They felt that the benefits outweighed the challenges, and they couched their assessment in the context of a 'free' service offer, expressing appreciation for the help provided by the Council. Most said that they were able to rest and recover while at the accommodation. In terms of reducing community transmission, all participants except one reported that no household member tested positive for COVID within 10 days of them returning home. Participants also highlighted the speed and efficacy of the CRT.

5.4 WHAT WORKED LESS WELL

Overall, the facilities were poorly experienced by most residents, despite them valuing the help of the service. Based on their accounts, the inconsistency and level of information provided by the service – and at the facilities – could have been improved to help them plan and manage their stay. Most said that they were not given information about the option to have a household member support them in hotel isolation.

Other barriers to accepting the offer included: being able to isolate at home; wanting to stay with family; caring responsibilities; mental wellbeing concerns; concerns about moving when ill; infection control concerns; and pre-existing health conditions and having regular NHS supervision.

Most participants complained about some aspect of their room, highlighting their inability to have a sense of control over the environment in which they were isolating, and the discomfort that this caused them. Reportedly, no adaptations were made to the facilities to make the accommodation suitable for long-term stays.

Food was one of the biggest problems. Food provided for cooking was missing key ingredients (e.g. oil, salt, sugar). Some participants were given food parcels, but they were in rooms with limited or no cooking facilities. Not all knew that they could get support for ordering food online or, if struggling, access free food through Newham Food Alliance. A few managed to get food vouchers or reimbursement after ordering online, worth £10 a day, while some had to

spend their own money. One spent £75 for a 5-day stay; another spent £200 for a 10-day stay. Some received only one food parcel during their stay, while others received two or three; some received parcels along with hot food in the hotel. Others spoke about the quality and quantity of food; 2 said that they were unwell and needed healthy and plentiful food, but could not get it, which was not good for recovery. Diet is very subjective, and participants' accounts show how food was pivotal emotionally, physically and psychologically to how they coped in Hotel Isolation. It was a challenge to accommodate the ethnic and religious diversity of participants regarding diet, and, in most cases, hotel facilities and food parcels did not satisfy their needs. In addition, COVID-19 can affect taste and smell, as well as energy to cook for oneself.

Transport was also an issue. Some participants had to wait for a taxi to be arranged, and they had to stay one or two nights at home after the hotel was booked, while others moved on the day of booking. Some were given a second taxi to get bedding from home; in contrast, one participant had to ask her son to drop off bedding – and he received a parking ticket at the hotel.

Participants commented on the lack of outdoor space, and their unease about sharing a balcony with other guests for exercise and fresh air. Dincer and Gocer's (2021) study shows that outdoor access via a balcony or operable window was a fundamental requirement. Some were concerned about different guests using the same facility, specifically, refugee families. Multiple agencies using one facility to house vulnerable groups evidently did not rest well with a minority of participants.

Some found their room too hot, while others said that it was too cold. Those who complained about the heat were advised to order a fan online, or to get a friend to deliver one. A few highlighted inadequate hygiene (e.g. bedbugs and bugs on the floor). One said that they were shocked to find that there was no bedding or pillows, just a plastic mattress cover. Another said that they were informed about this beforehand, and refused the offer after they were asked to take their own bedding and food.

A major concern for several participants was lack of information about how to negotiate and navigate the facility. For some, there was no receptionist on arrival, no information about the use of facilities, what they could and could not do when self-isolating, no coordinated response to their stay, or information on the timing of PCR and LFT tests. One reported waiting for thirty minutes at reception for the room key, encountering other hotel guests. Hotel staff told her that she should have had her room number (provided to the Council) and gone to the room straightaway.

Participants' concerns were exacerbated when they lacked the means to connect to family and friends from their room. This sometimes resulted in the opposite of the desired effect, as participants spent time in reception using Wi-Fi – there was no information about guest restrictions – or spending their own money to buy extra data from mobile networks.

Most participants reported that they were not aware of the COVID support payment, and 3 who applied were not successful. Only 1 participant was able to get a £200 micro-grant, having

received information from a friend who was a food bank officer. Four said that they had lost money while using the service. Of the 14 participants, 6 (43%) were not getting paid during self-isolation; 4 (29%) were receiving sick pay; 3 (21%) were getting the full amount, while 1 (7%) did not declare any sort of payment.

Of participants, 10, including 2 household contacts, said that Hotel Isolation had a negative impact on their mental health and wellbeing. Most, if not all, felt isolated and depressed, and 2 reported that they became physically unwell. Most at risk were those with pre-existing mental health issues, who reported feeling increased anxiety, depression and suicidal thoughts. All except one said that they were not informed about Newham Connect befriending service.

There was an unmet expectation that medical advice would be provided as part of the service (10 said that they did not receive any medical check-in). For instance, daily symptoms were not recorded or reported. They were dissatisfied with the lack of clinical advice, and they wanted support to understand if their symptoms had worsened.

Participants required appropriate language support to get further information about the services. It appears that the better a participant's English-language ability, the more personalised service they received. Some reported that information provided verbally was hard to understand and remember (e.g. about the befriending service or self-isolation payment). Leaflets to provide information about services in different languages were needed. Use of social media for accessibility to various features of the service, such as a website and video clips in community languages would have helped. Inclusive design, including diverse images, language and readable fonts, reflecting participants' ages, ethnicities, ability and experience with technology would have enabled informed choices about how to better self-isolate, both in and out of the Hotel Isolation service.

Most accounts refer to the experience as being lonely, stressful or traumatic (8 individuals, 57% of the sample, reported having had a mostly negative experience), but this is in part down to the prolonged period of lockdown, separated from loved ones. The Council were systematically evaluated favourably regarding the appropriateness and effectiveness of the measures. Of the interviewees, 50% (7) did not leave the hotel during isolation. More people broke their isolation in the hotel than in their homes.

To paraphrase Bargain and Aminjonov (2020), public trust in institutions is a key determinant of compliance with public health guidelines, especially in times of crisis. It was therefore good to see that all levels of compliance improved over time. This provides valuable insights into how the Council can earn the trust of residents, where and how to improve outward-facing functions/mechanisms to reach and support vulnerable members of the community, and ways of working with the private and third sectors.

6. IMPACT OF COVID-19 ON THE HEALTH AND ECONOMIC WELLBEING OF YOUNG PEOPLE ACCESSING SUPPORT SERVICES: LIVING IN LIMBO?

6.1 BACKGROUND

The UK has an inconsistent youth support service infrastructure, and it became even harder to provide and access high-quality holistic support services during the pandemic, leaving many young people alone to cope with challenges to their mental health and wellbeing, and to plan for the future. Lockdown disproportionately affected young people's aspirations, health and opportunities – through impacts on family life, school, work and training, and through social isolation, economic hardship, threats of cuts to public spending, and the physical and emotional effects of rising unemployment and widespread loss and grief. Understanding how these factors affected young people is more important than ever, particularly in the context of Brexit. Society cannot afford another lost generation.

Children and young people are at higher risk of developing mental health difficulties than adults. Lack of regular interactions with friends resulting in loneliness is more likely for adolescents, and this is not necessarily diminished by remote communication. Loss of structure and routine due to not being able to go to work or college/university was also associated with poorer mental health. Young people experienced barriers to engaging with remote mental health support and services. For example, due to an overwhelmed system, referral was very slow. Social anxiety, especially with their voice, sometimes prevented young people utilising telehealth interventions.

A report by YoungMinds in February 2021 showed that most young people believed that the COVID crisis will have a long-term negative effect on their mental health (Thomas, 2021). Asked to list three factors that had the biggest negative impact, the leading answers were: loneliness or isolation (58%); concerns about school, college or university work (51%); not being able to do usual activities (39%); concerns about someone you know getting ill (36%); not being able to get mental health support (20%); relationships with people you live with (19%); and concerns about getting a job (14%).
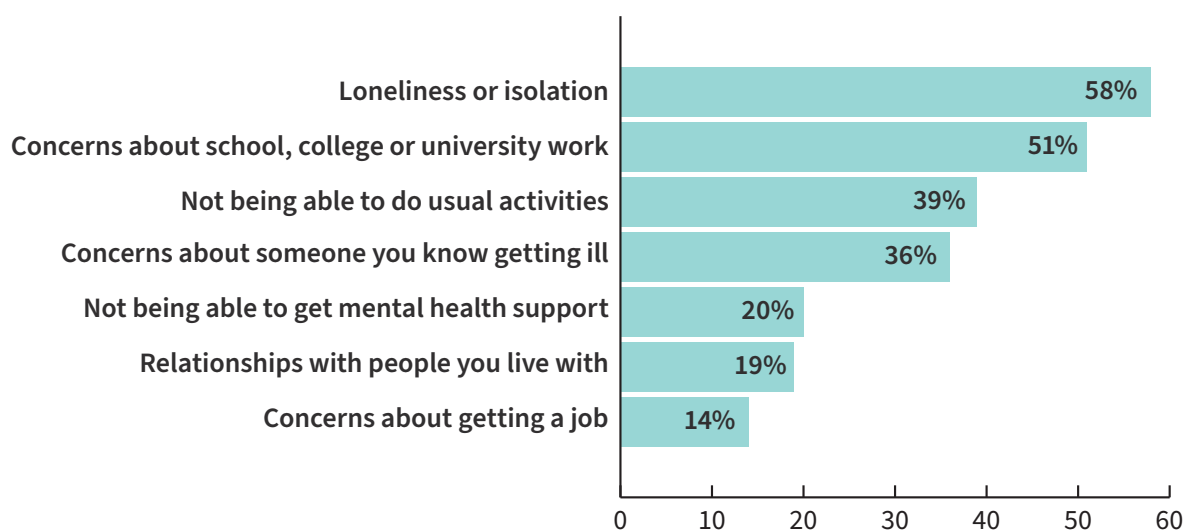
6.2 EVALUATION

The study took place between September and December 2021, using a mixed methods design to better understand how Youth Information, Advice and Counselling Services (YIACS) addressed COVID-19 challenges. In-depth interviews and focus groups with Youth Access (YA) members (n=10) and young people (n=20) obtained a multidimensional perspective on individual needs of service users, and the response of YIACS to emerging employment and welfare needs. The study revealed innovation to reach and engage service users, and the resilience and altruism demonstrated by service providers, who shared insights about what is needed as part of COVID-19 recovery. It also demonstrated the resilience of service users, and provided a valuable window on the limbo and frustration experienced by young people during the pandemic.

6.3 YOUNG PEOPLE

Access to some services became more equitable, faster and more youth-centric in response to the pandemic, and some YA members widened their reach. Research participants self-referred or were referred by a third party. Around half reported that the services they received met their expectations very well during lockdown. Around 67% said that they were neither satisfied nor dissatisfied with resources on the YA website, and 33% felt very satisfied with online support and resources, and prioritised emails and e-newsletters (89%), text and website (44%), and direct contact with services (33%) as the top choices for receiving or sharing information about services during autumn/winter 2021/2. About half (55%) said that they were very satisfied with the level of access and engagement with support workers (e.g. receiving information about services, being asked their views and feeling listened to), and 33% were neither satisfied nor dissatisfied. Participants said that they would like to see a blended approach of in-person and virtual appointments continue, due to the flexibility it offers.

Many young people in the study identified the unique role that young people could play in creating a safer community, and in taking on volunteering opportunities and caring for loved ones. However, YA members recognise the challenge of better bridging academic studies and the world of work, and of instilling in young people the transferability of skills and knowledge to succeed.

6.3.1 EDUCATION

Among young people who were studying, some used lockdown to reassess their situation and focus on applying for postgraduate studies – if money allowed – while others decided to leave their course and enter work – if they could find it. Despite undertaking self-directed work to build skills and confidence, most described struggling to access careers advice. Young research participants needed more support services to cope with often self-directed home schooling and to build resilience in higher education; accessing appropriate training opportunities and building self-confidence; and planning next steps in education, work and training.

Service providers identified the traditional disconnect between academic studies and work, and the need to introduce business and entrepreneurial skills training earlier, rather than at secondary school. The links between what is studied and its transferability into the workplace need to be understood. Young adults felt that higher education was not always needed, but that they were pressured into it, negatively impacting their mental health and wellbeing. Some viewed higher education as an escape route from troubled families, but they felt that there should be parity with other training and employment options, to reduce the fear of being a disappointment, and to avoid the burden of debt. They would like alternative valued pathways to success, and more opportunities for good-quality apprenticeships and employment mentoring. When university is the right path, young people need help to know the right degree in which to invest time, money and energy to lead to a meaningful career.

6.3.2 EMPLOYMENT

COVID-related restrictions had a significant impact on employment, including for young people, who in this case are a vulnerable group, often looking for their first job. Young people accounted for about two thirds of the total fall in employment from the start of the pandemic, and youth unemployment was almost four times higher than for the rest of the working-age population.

Service providers have focused less on graduates locked out of work and with low professional esteem, and have worked more with those not in education, employment or training (NEET), vulnerable clients, or primary or secondary school ages, leaving an unfilled gap for young people who require a 'job' above a 'career'. Many young people with pre-existing problems struggled more during the pandemic, limiting their job options to retail, beauty, and creative industries.

Most were not optimistic about future work plans, and they required help to apply for jobs, write a personal statement, build confidence for an interview, find work placements and gain experience of a work environment. This was especially true for young black males and those with invisible disabilities. It is a challenge to access job opportunities while older, qualified and experienced furloughed and unemployed adults also want to rejoin the workforce. Cities and large towns need to level up, so young people do not need to move for more highly skilled and well-paid jobs.

Employment is a key social determinant of health, and it has a broad range of consequences for psychological wellbeing (CSDH, 2008; Modini et al., 2016). The conditions in which people work are socially structured, and those with limited economic, social and cultural resources are more likely to be exposed to job instability and unemployment (Dahlgren et al., 2006).

6.3.3 ACCOMMODATION

Young participants also needed support regarding relationships with people they lived with. Some had returned to the parental home. This was not always voluntary, but due to financial hardship. Educational disruption forced some to engage in independent learning, which most struggled with. The effects of being out of education and isolating away from significant others led to loneliness and fragmented support networks. Accessing support groups online was mixed, when it occurred. Isolation at home was not hard for all young people; prior to COVID, a few already lived with social anxieties. The impact of school closures also meant that a few who struggled with school culture were able to successfully complete their GCSE exams at home (although this was rare).

6.3.4 YOUNG PEOPLE FROM BAME BACKGROUNDS

A survey of over 14,000 young adults by the charity Mind found that existing inequalities in housing, employment, finances and other areas had a greater impact on the mental health of people from BAME backgrounds than on white people during the pandemic (Mind, 2020). Young black men have faced historic injustices, and many of the challenges they encounter have a long-term and devastating effect on their psychological wellbeing. A survey showed that black men aged 16–25 were among the hardest hit by job losses, and they were more likely to report a fall in income because of lockdown. They also experienced significant inequalities in education. As a result, they were at high risk of mental distress compared to other young people (Abdinasir and Carty, 2021). The Runnymede Trust estimated that people of BAME background are much more likely to have experienced adverse financial consequences of COVID than white people (Runnymede Trust, 2020). They were also less aware of economic support measures, such as universal credit, statutory sick pay and the furlough scheme.

6.3.5 LGBTQ+ YOUNG PEOPLE

An online survey of LGBTQ+ youth in the UK confirmed that those who experienced greater impact of COVID and social distancing reported poorer mental health. Associated factors were lack of social support, negative interpersonal interactions, unsupportive and non-affirming living environments, and inability to access mental health services and gender-affirming interventions and support programmes (Jones et al., 2021). Some were unable to access gender-related care to monitor hormone levels, and gender-affirming surgeries were postponed. Support for sexual identification was felt to be concentrated in urban centres. LGBTQ+ support services are needed in small towns, and privacy at home is needed for online LGBTQ+ support.

6.4 SERVICE PROVIDERS

Of necessity, YA members pivoted from traditional service delivery models and innovated new ways of working. Virtual meetings connected team members in different geographical areas for the first time. The central steps to respond to the emerging employment and wellbeing needs of young people were: moving from in-person to virtual appointments, texting and mobile supportive conversations; developing new digital pathways to access services; extending working hours, and offering more flexible times for appointments; producing more online resources to encourage self-help, and updating online safeguarding policies; streamlining services, balancing need versus demand; pausing and renegotiating access with gatekeepers to groups of children and young people; switching from group-centred to individual-tailored work; and additional training and support to stay connected, and to cope with greater volume and/or intensity of work.

Service providers worked from home, often offering increased hours of support while upskilling with new technologies and coping with the impact of COVID. Trying to adjust and help service users, the prolonged nature of the pandemic and the complexity of needs of users created a burden on the workforce, who had limited access to support or informal discussions with colleagues to problem-solve together. Staff should be supported in knowledge transfer to learn best practice examples to step-down from high-volume and/or high-intensity caseloads – while balancing the issue of need over demand. The workforce needs to recover and systematically use evidence to innovate services based on the experience of the wider membership during the pandemic. Members highlighted critical success factors, including improved partnership working with third and public sector organisations, reduction in referral times between agencies, upskilling in technology, and enhanced processes such as team supervision.

Services struggled to return to normality and rebalance caseloads, complicated by new ways of working, and going in and out of lockdown. To help ease high numbers of users, services produced online self-help resources. Users requested in-person meetings for human contact due to prolonged isolation, as well as continuing online support. Although demand for services changes constantly between in-person and virtual appointments, users expect both to remain a feature of post-pandemic services.

A co-produced suite of online safeguarding policies and procedures is needed for safe access to digital spaces and effective practitioners. Young people should be protected by high-quality, evidence-based standards of ethical practice for online work, with resources being pooled and disseminated to enhance delivery. Providers highlighted the gap in safeguarding policies and procedures for online and home working, such as the privacy and safety of talking to potentially vulnerable young people at home.

Some providers innovated new digital front doors to services, whereas others faced challenges working with schools who mostly ran online classes. While one-to-one employment work continued, whole-group work stopped. Accessing groups through gatekeepers was problematic, resulting in providers changing their engagement with organisations supporting educating young people. This included quickly designing and launching prototype training packages and platforms, and adapting programmes to meet the needs of individuals rather than groups. Organisations collaborated to create clearly signposted and supported referral pathways for young people. Users reported that they undertook their own online searches to find help and guidance. Some were also referred, but providers mainly worked with known young people to help them through lockdown.

Findings indicated that the shift to remote service provision was mostly unproblematic and, for some, resulted in more frequent interactions with counsellors or psychologists. However, concerns were raised about accessing remote services if users experienced deterioration in their mental health or health condition. One stressed that when unwell, she loses much of her ability to articulate distress verbally, so a telephone consultation would no longer be useful. Others were concerned about what services they would be able to safely access if they became seriously unwell or distressed, or had a specific need. Limited communication from mental health services was identified as contributing to increased anxiety.

Keeping young people connected to the community, and reassuring them that services would continue to be there for them, was critically important. Members demonstrated that innovations in services can operate effectively outside buildings, providing virtual/telephone/text support and a work-ordered day in which members could participate. Services should be delivered by trusted practitioners, as well as by peer groups, who have insight into overcoming the challenges of starting their working lives.

Recovering from the pandemic, a review of methods used by members could discover best practice to improve services to provide a blended approach. Members should rethink pathways to virtual engagement, and how to restore some of the features that were lost during the pandemic, reviewing the ways in which service users were reached, engaged and referred, mapping formal and informal referral pathways during the pandemic, and changes in criteria, so as to widen access for young people.

7. COVID RECOVERY: MENTAL HEALTH SUPPORT IN NEWHAM – PREVENTION AND PROMOTION FOR BETTER MENTAL HEALTH FUND

7.1 BACKGROUND

Newham Council's Better Mental Health (BMH) programme aims to help, uplift and support at-risk groups impacted by the pandemic to access community-based mental health and wellbeing services. Arguably, the programme has improved health outcomes for children and young people, members of LGBTQ+ communities, Albanian refugees and migrants, Bajuni and Somali women, and people recently bereaved – including those with intellectual challenges. At least 809 residents directly benefited from the programme, all of whom were traumatised or retraumatised because of the pandemic.

The programme emerged from the Newham Council Mental Wellbeing Impact Assessment (2020), which aimed to better understand the impact of the pandemic on the mental wellbeing of residents. The PHE (now the Office for Health Improvement and Disparities [OHID]) Prevention and Promotion Fund for Better Mental Health provided Newham with further funding for several existing services, to increase service and community capacity, and to extend the service offer, particularly to those most adversely impacted by the pandemic. The pandemic had a deep but unequal impact, increasing existing and interconnected inequalities. The Assessment placed importance on addressing residents' growing fear and anxiety, isolation and loneliness, post-traumatic stress disorder (PTSD) and poor physical health. The funding required that the Council take a whole-system approach, be people and community centred, emphasise collaboration and partnership, tackle inequalities and take a life-course approach.

The Assessment is anchored in the Towards a Better Newham strategy (2020), which sets out the Council's plan to support residents, communities and businesses to recover from the impact of COVID. It builds on collaborative work with partners in mental health and wellbeing to tackle the complex circumstances of residents, known as the Newham Mental Health Wellbeing Partnership (involving NHS, Local Authority and Voluntary Sector partners and stakeholders). The programme has facilitated the realisation of the plan to stimulate Borough-wide thinking about how to support underserved and under-represented residents who are at risk or who have early signs of poor mental health.

The Noon Centre for Equality and Diversity at UEL provides a platform for collaborative high-impact research, community engagement and evidence-based interventions to enhance access, inclusivity and opportunities for all. The Centre envisages UEL and other universities at the forefront of partnerships generating data-driven research, meaningful dialogue with communities and partners in supporting attitudinal and policy changes for sustainable development. It promotes leadership and tools for pro-poor, inclusive, gender- and age-responsive, evidence-based targeted interventions that secure safety, resilience, livelihoods, health and wellbeing for all sections of society. In 2020, in the wake of the pandemic, the Centre launched its call to tackle issues of equality and diversity to create an inclusive society and fairer economy.

7.2 NEWHAM COVID-19 RECOVERY STRATEGY

In a borough disproportionately affected by COVID-19, the Towards a Better Newham Action Plan sets out the Council's approach to supporting the Borough to recover and build a stronger Newham for the future. Responses need to deal with the systemic nature of socioeconomic issues facing BAME communities. A key component is 'community wealth building', with the objectives of dealing with BAME underemployment, providing short- and long-term actions, local anchor support, skills and training, and supporting mental wellbeing.

The COVID-19 recovery strategy (health and wellbeing of residents and race equality – inclusive growth, quality jobs and fairness) has eight pillars:

1. Measures of economic success	**2.** Youth Empowerment Fund	**3.** Consolidated support services	**4.** 'Healthy residents'
5. '15-minute neighbourhoods'	**6.** Green economy	**7.** Fair deal for Newham workers	**8.** Objective-based investment

The disproportionate impact of the COVID-19 pandemic has been recognised through the human cost, the economic cost, and the social and health-related costs. Many of these components are linked to the 'intersectionality' of lived experiences during the pandemic – and to the heightened exposure of Newham residents health-wise, and socially and economically. Newham has had an increase in out-of-work claims. Of Newham residents, 39% work in the four highest risk sectors – construction, hotels and restaurants, other services and manufacturing. Newham also has a very high proportion of its population in deprivation (92%). There is also the highest level of 'double risk' from precarious housing and precarious income. These statistics provide a wider frame showing that BAME people disproportionality fit into a larger pattern of socioeconomic deprivation that is linked to employment, income and housing tenure status.

Newham's COVID-19 recovery strategy attempts to provide a roadmap for dealing with some of these challenges in a targeted and localised approach. However, without clear targets, data baselining, and a 'theory of change', the ultimate objectives may seem distant or uncertain, despite best efforts.

The Social Determinants of Health Framework provides some areas that are policy priorities, but there is still work to be done on tackling poverty, deprivation and employment-related challenges in Newham. Three main factors – income, education and occupation – determine socioeconomic position. Other factors are the structure of (multi-generational) households, overcrowded living environments, levels of poverty, access to health and care services, higher unemployment, higher rates of economic inactivity, migration status, geographic location and lower educational attainment, as well as language and cultural barriers. Other issues include 'overrepresentation of BAME persons in frontline roles, unequal distribution of socio-economic resources, disproportionate risks to BAME staff within the NHS workspace and high ethnic predisposition to certain diseases which have been linked to poorer outcomes with Covid-19' (Otu et al., 2020).

Also uncertain is the longer-term impact of the pandemic on the educational, social and economic futures of younger people (Kenway et al., 2020).

7.3 SERVICES

Local befriending schemes and a bereavement service received additional funding from the Council to support residents to emerge from the pandemic and reconnect with the community. Using a strengths-based approach (e.g. involving compassionate conversations and a racially responsive service), these services have innovated and tested different ways to better reach and engage their target populations.

7.3.1 NEWHAM COMMUNITY BEREAVEMENT SERVICE

The Newham Community Bereavement Service (CBS) has been in place since 2017, funded by the Borough. As a result of COVID, additional capacity was funded by the Council from August 2020, with the BMH Fund continuing this enhanced support for one year from May 2021. This was expanded to include early support for residents bereaved by COVID or other sudden death, support for residents experiencing long-term trauma/PTSD, and specialist provision for those with a learning disability/autism, as this group was adversely impacted by COVID.

7.3.2 YOUR TIME

Your Time was developed rapidly at the height of the pandemic, originally aimed at supporting vulnerable children and young people (5–18 years old; up to 25 for those with SEND) in crisis by providing a weekly befriending catch-up delivered by the HeadStart Youth Practitioner Team. In collaboration with Child and Adolescent Mental Health Services (CAMHS), it also led on developing and coordinating a new Multi-Agency Collaborative (MAC), with the aim of reducing the impact of waiting for a CAMHS service (or for those who did not meet the threshold) by providing not only the direct Your Time offer, but also a pathway to timely therapeutic support through interventions provided by 47 organisations across the Borough. OHID funding has supported a coordinator post for the MAC to continue this work.

7.3.3 CONNECT NEWHAM

Connect Newham was established in 2020 to provide medium-long-term telephone befriending for those who are socially isolated to improve their mental health and wellbeing. The service is delivered by a partnership of local VCFS organisations, primarily by volunteers from the community. OHID funding has supported expansion into communities currently not being reached, such as the Roma, Somali and Albanian communities. The programme has funded three VCS providers: Kulan Somali Organisation, Bajuni Women's Advocacy Group and Shpresa Programme. The funding also supports a consortium central hub and spoke model, emphasising training and capacity building to create a sustainable service provided by the community groups.

While CBS and Your Time are professional services focused on mental health support (among other areas), the Connect Newham organisations offer indirect mental health support that is not always explicitly voiced – either due to cultural stigma around 'mental health', or due to their focus on holistic, and often practical, 'neighbourhood' support and delivery.

7.4 EVALUATION

The programme ran from May 2021 to May 2022. The ICC was commissioned by Newham Council to undertake an independent evaluation of the programme, which was carried out between May and June 2022, interviewing 22 participants on the phone, on Teams and WhatsApp, using a semi-structured interview schedule.

The programme had 809 unique direct beneficiaries: 529 (65%) females and 238 (29%) males. Ethnic groups were 143 (19.56%) white British, 86 (11.76%) white 'other', 79 (10.81%) black African, 77 (10.53%) mixed, 75 (10.26%) Bangladeshi, and 38 (5.20%) in the 'other' ethnic category; 173 came from the 10% most deprived LSOAs in England.

Clients on the programme benefited in building resilience, and in overall wellbeing, while the workforce was arguably empowered, and increased their confidence to become more targeted in outreach approaches/techniques, and more aware and responsive to the complex needs of residents. Outcomes were achieved in part through refocusing the projects on how they reached and engaged residents, providing age-appropriate and culturally sensitive individualised support, including in appropriate languages, with staff matched to the target population. This involved enhancements to systems and processes, increasing numbers of staff and volunteers, providing training, and often innovating the space and place in which to provide support sensitive to people's cultural identity or heritage. Co-produced, tailored and flexible support plans captured clients' needs, and served to increase their agency and autonomy. A range of accessible ways for clients to find information, and blended ways to engage with the services, whether in-person (within walking distance), by phone or online, allowed clients to decide what is most comfortable for them. An outreach workplan engaged local partners, and built cross-agency and public awareness of community-based mental health and support services.

All the services except Your Time reached or exceeded their target numbers by the end of the funded period. The slightly lower number reached by Your Time is likely due to the length of time they work with clients. The programme reached residents aged 5 to 65+, showing that the wellbeing of all ages was addressed, and there was an uptake of Bangladeshi (Your Time), Pakistani (CBS) and African and white 'other' (Connect Newham) residents for early mental health support.

The Council encouraged providers to co-produce services as a catalyst for action, rather than serving as central providers themselves. They established mutual responsibilities and expectations, demonstrated in sharing roles by removing tightly defined boundaries between

professionals and recipients, and between producers and clients of services. Still, the Council could have done more in the facilitator role in setting up a learning network to coordinate collective action in the co-design and co-delivery of outreach approaches, allowing all parties to share learning and to problem solve together in real time.

7.4.1 STRENGTHENING COMMUNITY-BASED CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

The PHE COVID-19 mental health and wellbeing surveillance report suggests that while children and young people generally coped well during the pandemic (March to September 2020), other evidence indicates that some – especially those who are disadvantaged economically, females, and those with pre-existing mental health needs – experienced greater negative impacts on mental health and wellbeing.

Part of the Newham offer is social prescribing to support young people. This is a relatively new initiative, about which there is very little research (see Bertotti et al., 2020). Most schemes to date have targeted the over 50s (Torjesen, 2016), but as a recent literature review suggests that up to half of adult mental health disorders begin in adolescence (Jones, 2013), social prescribing has potential as a preventative intervention to improve outcomes for children and young people who do not meet the threshold for intervention from CAMHS (NHS England, 2017). An important aspect of social prescribing is its focus on a holistic, rather than a specific, interaction with the client, through which their multiple needs and aspirations are considered simultaneously, and their agency is central to the decision-making process.

7.4.2 STRENGTHENING COMMUNITY-BASED SUPPORT FOR OLDER PEOPLE

The pandemic highlighted the need for social connection, and the need to think about the systems and services which enable this makes the work of the OHID programme even more important. Loneliness can affect anyone – teenagers and young adults, new parents, carers and the recently bereaved, students starting university, those with disabilities, those moving to a new area of the country, and refugees. However, older people experience high levels of loneliness compared to other age groups, and they may be at risk because of declining health and loss of close relationships or social networks.

The Home Office has piloted schemes to identify and support older people experiencing loneliness, e.g. Safe and Connected, in conjunction with Royal Mail, private enterprise, local authorities and the voluntary sector. Postal workers called on older people who signed up to participate, as part of their usual rounds. They asked a standard set of questions to assess individual need, with responses captured via their hand-held work devices. A professional from the local authority or the local voluntary sector analysed the results and signposted the individual as necessary to friends, family, neighbours or voluntary services. This helped to reduce risk of loneliness, and to address other issues.

Other examples include the Government's Sporting Future strategy (research shows that involvement in sports clubs is effective in reducing loneliness in older people), and the Inclusive Transport Strategy, which aims to make the transport network accessible for disabled and older people, enabling them to be more mobile, and to establish and maintain social connections.

7.4.3 INSIGHTS INTO ACCESS: COMMUNITY BEREAVEMENT SERVICE (CBS)

The CBS was used by 462 clients: 18% were disabled; 65% were non-disabled; 18% were of unknown disability status. Significantly more women (73%) than men (19%) accessed the service. The largest ethnic group was white (25%), followed by Asian (24%) and black (21%). The largest white group was white British (18% of all clients); the largest Asian group was Pakistani (7% of all clients); and the largest black group was black African (8% of all clients). Clients of mixed race made up 10% of all clients, and other ethnicities, including those who did not state their ethnic group, made up 20%.

Between May 2021 and March 2022, the service made significant changes to the way they worked and how they promoted the service, updating their information, leaflets and website. They appointed a new Coordinator, and a Lead Counsellor for learning disability and autism, they improved data management to enhance the way they collected information, they moved offices to be more accessible for the community, and they improved space availability for the team.

The recruitment of men was a priority, as men are under-represented in this service. The CBS set a minimum of two sessions to be delivered per quarter to men, as well as other hard-to-reach groups. This target was reached in Quarter 3 for both men and other groups, but it was not reached for men in Quarter 4.

The CBS has a strong sense of coherency, and the service design widened to reflect emerging needs. They have seen shorter waiting times, tailored support being delivered for adults with SEN, and longer involvement for adults with complex bereavement needs, including development of group sessions. Newham is seeking to become a bereavement-aware borough at a strategic level. The funding has allowed the service to increase its workforce and conduct training on building cultural competencies. It has become more accessible, providing free or low-cost therapy, and an opportunity to build social support networks.

Challenges encountered include a lack of step-down provision, maintaining continuity of counsellor, and digital access problems. The workforce had to deal with complex bereavement needs and a high volume of clients, which was a strain while working remotely. Going forward, training is needed in the specialist areas that they are being asked to focus on, including clients with special needs. Another challenge is providing in-person sessions when workers have been contracted to work remotely, and there is a lack of space to accommodate everyone. They also need to improve data safety and to streamline three data sources into one system. An improvement would be a system to manage the flow of referrals to and from GPs and social workers. Most importantly, they need office space for the team to connect, learn and share support.

7.4.4 INSIGHTS INTO MENTAL HEALTH AND WELLBEING MEASURES: YOUR TIME

Children and young people reported fatigue and boredom while confined with their families and separated from friends. For some, this exacerbated existing mental health problems, or brought on low-level depression and social anxiety. More young people accessed services to better cope with lockdown: 280 children and young people were supported through the Your Time service as part of the programme; the largest category was 5–17 years of age (97%), followed by ages 18–25 (3%). The largest ethnic category was Asian (31%), followed by white (31%) and black (22%). The largest Asian subcategory was Bangladeshi (18% of all clients), the largest white group was white British (19% of clients), and the largest black group was black African (9% of clients). Mixed race clients represented 11% of clients, and other ethnicities, including those who did not state their ethnicity, represented 5%.

Young black men were at high risk of mental distress during the pandemic, compared to other groups of young people (Abdinasir and Carty, 2021), and they lacked trust in services, especially when they did not see people resembling themselves.

Using an Outcome Star measure, 'School, training and work' was the area in which most clients made most significant progress; 'Healthy lifestyle' was the area in which fewer made progress. 'Where you live' was the area in which most maintained a high score. 'Self-esteem' and 'Healthy lifestyle' were areas in which most dropped back; 'School, training and work' was the area in which fewer clients dropped back. The results indicate that clients were most engaged in their support plan when they exercised greater control in that sphere of life. Lack of progression in the Outcome Star does not mean a lack of motivation by the client, or that the service failed the client; the measure is a proxy to identify what matters most to clients for better mental health and wellbeing, and where the service has made in-roads.

7.4.5 INSIGHTS INTO HOLISTIC RESPONSE: CONNECT NEWHAM

Connect Newham's approach focused on prioritising the cultural needs of three small minority groups by empowering volunteers to develop trusting social relationships with clients in their homes and in the community, and they were able to reduce social and cultural isolation.

The largest group that accessed Connect Newham were 26–64-year-olds (49%), followed by those aged 65+ years (24%), and those aged18–25 (21%); 15% of clients were disabled, 79% were non-disabled, and 6% were of unknown disability status. Significantly more women (76%) than men (18%) used the services.

The largest ethnic group was white (42%), followed by Asian (12%) and black (4%). The largest white group was 'white other' (33% of participants); the largest Asian group was 'other' Asian (4% of participants); and the largest black group was black African (27% of participants). Mixed race clients represented 3% of all clients, and other ethnicities, including those who did not state their ethnicity, represented 10%.

The subcategory 'white other' reflects Albanian residents, who hold a unique position of being white and predominately secular Muslims. Shpresa Programme ('Hope' in Albanian) is a UK-based organisation that runs several complementary schools for Albanian-speaking children from refugee, asylum and migrant backgrounds. It is a user-led organisation that advances the education and training of Albanian-speaking people in the UK to enable them to take full and active roles in their communities.

All leads described positive impacts for their clients linked to a holistic approach. Common themes included a more effective structure for their befriending activity, and increased awareness and understanding of loneliness and isolation. The befriending model initially used phone contact, as it was introduced during lockdown; it has now moved to more in-person support. One lead reported initial difficulties with the lack of in-person contact, and some clients were keen to return to this. Delivering support in community languages is also central to its success.

7.4.6 BARRIERS AND FACILITATORS TO IMPLEMENTATION

The evaluation was unable to address the degree to which service enhancements helped to mitigate the mental health impact of the pandemic on the targeted communities, because the short-term nature and the size of the programme limited population-level assessment. However, there was an increased uptake of services by at-risk groups that exceeded the predicted numbers at the start of the programme. Although the positive mental health outcomes of the services might not be evident across the system, increased engagement in early help suggests how the enhancements have contributed to healthier behaviour and increased health literacy in the targeted communities.

The benefits and impact of the service enhancements from a client perspective are evidenced in the increased take-up of services through widening pathways to access services through self-referral (where it did not previously exist), and sustained engagement in (formalised and reviewed) co-produced support plans that focus on what matters most to the service user, and on providing holistic support. The programme has increased communities' health and bereavement awareness, reduced isolation and loneliness by improving clients' connections to their communities, and provided activities and new stimuli, adding variation to daily routines and breaking inactivity.

The benefits and impact of the enhancements from the service providers' perspective include: recruiting a critical mass of volunteers to help increase their capacity to match demand on the services; the new workforce better matching the ethnic and linguistic needs of the pre-existing and/or targeted client groups, thus ensuring that cultural sensitivities and ways of communication are addressed; and the professionalisation of services, leading to more efficient and effective ways of working. Providers were able to offer services for a longer period, with

reduced waiting times. They increased their capacity to see clients, while providing more tailored services with co-produced support plans. They also gained a better understanding of the communities they serve, and they were able to mobilise community assets, establish new stakeholder partnerships and aspire towards whole-system working (CBS, Your Time).

The best model(s) of delivering these services from the combined perspectives of clients and providers are community-based person-centred modes, with the caveats of having high levels of cultural competency in the workforce, and visibility of the service across the whole system, breaking down the barriers that might prevent engagement, such as language, finance and accessibility, as well as referral routes. Mental health and wellbeing problems can seldom be resolved in the short term, and therefore sustainable statutory support for community-based mental health and wellbeing services is needed for them to continue supporting underserved and under-represented residents. Sustained funding is needed to secure the longevity of service enhancements, and to build trusting relationships.

The assumption behind this programme is that fears – real or imagined – form a barrier to sections of the community accessing early help with mental health and wellbeing problems at a stage when they can be treated relatively straightforwardly. The strategy employed in part addressed these fears. The emergent themes of holistic support, access, place and space, systems and processes, training and capacity building provide partial insight into what service enhancements matter most to staff and clients in providing and receiving a responsive service.

Reaching populations from ethnic minority groups can be difficult due to barriers such as language, beliefs, stigma, religion and social network. Research participants illustrated the benefits of strategic volunteer recruitment to match clients' gender, ethnic, cultural and linguistic backgrounds. Such matching is one way to ensure cultural competency in the service, ensuring its effectiveness and acceptability for clients. Project staff reported an increase in reaching Asian communities (which was a problem before) through having counsellors speaking their mother tongues, although this could still be improved. There is no systematic, sustainable way to recruit and train appropriately matched volunteers. Through its Volunteering Strategy (2022), the Council should offer community-based services to facilitate a coordinated approach to recruit and train volunteers who match residents' demographic profiles.

Widening access and increasing uptake of underserved and under-represented sections of the community is not only applicable to ethnicity; it is also relevant to adultism/ageism experienced by children and young people, ableism faced by people with learning disabilities/autism, and homophobia faced by LGBTQ+ communities in their experience of mental health support services.

There is a need for inclusive and appropriate meeting spaces for practitioners and clients. Spaces need to be accessible, culturally acceptable and consistent, avoiding settings where stigma may arise. In terms of office space, access to co-working space would enable the increasingly remote workforce to come together to bond, share and learn as needed, and would help reduce work pressure and isolation. Key partners across the Health and Social

sector, including larger community-based organisations, should consider how best to identify and unlock social infrastructure and/or publicly owned assets to ensure partners can access affordable and acceptable co-working space to accommodate the growing workforce and client group.

Where appropriate, meeting with clients should also focus on wellbeing through home visits, community walks and advocacy to support isolated and lonely women, and a shift from classroom-based to remote support for children and young people. The Your Time service enhancements ensured that vulnerable children and young people could use self-referral pathways that provided greater anonymity and separation between school and personal life, avoiding the stigma of school-based interventions.

There is a need for high-quality, specialised training for new and established staff members and volunteers (e.g. trauma training, complex bereavement, such as the loss of a child, and bereavement counselling for people living with a learning disability).

Improvements in referral management and streamlining are needed across the system, including an engagement plan to identify and engage key stakeholders involved in referral of clients, and improvements in collaboration across health and social care to reduce referral times. Programme partners have worked in isolation from each other; a community of enquiry and/or thinking circle is needed to help consolidate relationships, reduce waiting times and streamline referral pathways. Partnership working helped to streamline referral systems, and, indirectly, the increase in self-referral absorbed demand on statutory services during the pandemic. GPs and social workers are best placed to make referrals to the service, but they lack understanding of community-based mental health and wellbeing services. There is no Borough-wide referral system to help make referrals to step-up or step-down from the community-based mental health and wellbeing services. It is a challenge to apply eligibility criteria to support clients to move on to other services, which can be problematic when clients do not meet service thresholds (e.g. due to postcode). Key partners across the Health and Social sector should consider how best to innovate and test processes to simplify referral and other pathways between partners involved in delivering services for residents experiencing poor mental health and wellbeing. To improve take-up and understanding of thresholds, and to speed up referral times between services, a common referral pathway framework is needed.

To take account of the mobile and marginalised communities in the Borough, a mixed economy of service provision is needed. Key strategic partners across the Health and Social sector should continue to commission a mixed economy of services for residents to meet their mental wellbeing and health needs, including a range of community-based services and support organisations to achieve sustainable growth and to preserve autonomy, scale and agility, while expanding visibility, accessibility, capacity and efficacy of community-based services.

Key partners should continue to commission blended delivery models using online and in-person services. A significant insight from the pandemic is the benefit of having multiple pathways available to help reduce inequalities in access and to empower residents to engage and participate in services.

REFERENCES

Abdinasir, K. and Carty, S. (2021) Young Black Men's Mental Health During Covid-19: Experiences from the Shifting the Dial project. **www.centreformentalhealth.org.uk/wp-content/uploads/2021/03/ CentreforMentalHealth_ShiftingTheDial_YBM_Covid_0.pdf** (Accessed 15 July 2024).

Bargain, O. and Aminjonov, U. (2020) 'Trust and compliance to public health policies in times of COVID-19'. Journal of Public Economics, 192, 104316.

Bertotti, M., Frostick, C., Sharpe, D. and Temirov, O. (2020) A Two-Year Evaluation of the Young People Social Prescribing (YPSP) Pilot. Institute for Connected Communities, University of East London.

Brooks, S.K., Webster, R.K., Smith, L.E., Woodland, L., Wessely, S., Greenberg, N. and Rubin, G.J. (2020) 'The psychological impact of quarantine and how to reduce it: Rapid review of the evidence'. Lancet, 395, 912–920.

CSDH (Commission on Social Determinants of Health) (2008) Closing the Gap in a Generation: Health equity through action on the social determinants of health. Final Report, Geneva.

Dahlgren, G., Whitehead, M. and World Health Organization (2006) Levelling Up (Part 2): A discussion paper on European strategies for tackling social inequities in health. Copenhagen: WHO Regional Office for Europe.

Dincer, D. and Gocer, O. (2021) 'Quarantine hotels: The adaptation of hotels for quarantine use in Australia'. Buildings, 11 (12), 617.

Edmiston, D., Geiger, B.B., de Vries, R., Scullion, L.C., Summers, K., Ingold, J., Robertshaw, D., Gibbons, A.R. and Karagiannaki, E. (2020) Who are the New COVID-19 Cohort of Benefit Claimants? Welfare at a (Social) Distance Rapid Report# 2.

Institute for Connected Communities (2022) Newham Council Welfare Check-in Call Pilot: Learning from a rapid evaluation 2021–2022. Evaluation Report.

Jones, P.B. (2013) 'Adult mental health disorders and their age at onset'. The British Journal of Psychiatry, 202 (s54), s5–s10.

Jones, B.A., Bowe, M., McNamara, N., Guerin, E. and Carter, T. (2021) 'Exploring the mental health experiences of young trans and gender diverse people during the Covid-19 pandemic'. International Journal of Transgender Health, 24 (3), 292–304. **https://doi.org/10.1080/26895269.2021.1890301**.

Kenway, P., Street, C., Holden, J., Tunstall, B., Chandran, C. and Ayrton, C. (2020) People and Places in London Most Vulnerable to COVID-19 and its Social and Economic Consequences.

London Borough of Newham Council (2021) Children and Young People's Joint Strategic Needs Assessment. London: Newham Council. **www.newham.gov.uk/downloads/file/3607/cyp-jsna-august-2021** (Accessed 27 May 2022).

MHCLG (Ministry of Housing, Communities & Local Government) (2019) 'English indices of deprivation 2019' [Statistical release]. **www.gov.uk/government/statistics/english-indices-of-deprivation-2019** (Accessed 5 May 2022).

Mind (2020) 'Existing inequalities have made mental health of BAME groups worse during pandemic'. **www.mind.org.uk/news-campaigns/news/existing-inequalities-have-made-mental-health-of-bame-groups-worse-during-pandemic-says-mind** (accessed 15 July 2024).

Modini, M., Joyce, S., Mykletun, A., Christensen, H., Bryant, R.A., Mitchell, P.B. and Harvey, S.B. (2016) 'The mental health benefits of employment: Results of a systematic meta-review'. Australasian Psychiatry, 24 (4), 331–336.

Newham Council (2020) Mental Wellbeing Impact Assessment Toolkit. **www.newham.gov.uk/downloads/file/3267/mental-wellbeing-impact-assessment** (Accessed 1 August 2022).

Newham Council (2020) Well Newham: 50 steps to a healthier borough. **www.newham.gov.uk/downloads/file/2554/50-stepsevidencebase-final** (Accessed 1 August 2022).

Newham Council (2021) State of the Borough Report 2021. **www.newham.info/wp-content/uploads/2021/07/State-of-the-Borough-2021-1.pdf** (Accessed 5 May 2022).

Newham Council (2021) Test, Trace, Isolate Insights. **www.newham.gov.uk/downloads/file/2855/test-trace-isolate-newham-insight-report-2021** (Accessed 2 February 2022).

Newham: Key Statistics (2021) Compost London CIC. **https://compostlondon.org.uk/resources/** (Accessed 7 July 2022).

NHS (National Health Service) (2020) 'NHS Long Term Plan'. **www.longtermplan.nhs.uk** (Accessed 18 August 2022).

ONS (Office for National Statistics) (2022) 'Population and Household estimates, England and Wales: Census 2021'. **www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/populationandhouseholdestimatesenglandandwales/latest#population-and-household-estimates-england-and-wales-data** (Accessed 6 July 2022).

Otu, A., Ahinkorah, B.O., Ameyaw, E.K., Seidu, A.A. and Yaya, S. (2020) 'One country, two crises: What Covid-19 reveals about health inequalities among BAME communities in the United Kingdom and the sustainability of its health system?'. International Journal for Equity in Health, 19 (1), 1–6.

Pagel C. (2021, 27 January) 'Covid-19: How to break the cycle of lockdowns'. BMJ Opinion.

Runnymede Trust (2020) 'Over-exposed and under-protected: The devastating impact of COVID-19 on Black and minority ethnic communities in Great Britain'. **https://cdn.prod.website-files.com/61488f992b58e687f1108c7c/61c31c9d268b932bd064524c_Runnymede%20Covid19%20Survey%20report%20v3.pdf** (accessed 15 July 2024).

Thomas, E. (2021) Coronavirus: Impact on young people with mental health needs. YoungMinds: UK. **www.youngminds.org.uk/media/esifqn3z/youngminds-coronavirus-report-jan-2021.pdf** (accessed 15 July 2024).

Torjesen, I. (2016) 'Social prescribing could help alleviate pressure on GPs'. BMJ: British Medical Journal, 352, i1436. **https://doi.org/10.1136/bmj.i1436**.

Williams, S.N., Armitage, C.J., Tampe, T. and Dienes, K. (2020) 'Public perceptions and experiences of social distancing and social isolation during the COVID-19 pandemic: A UK-based focus group study'. BMJ Open, 10 (7), p.e039334.

University of
East London