COVID-19 Health Inequalities Impact Assessment for the North East
Qualitative Workstream Report

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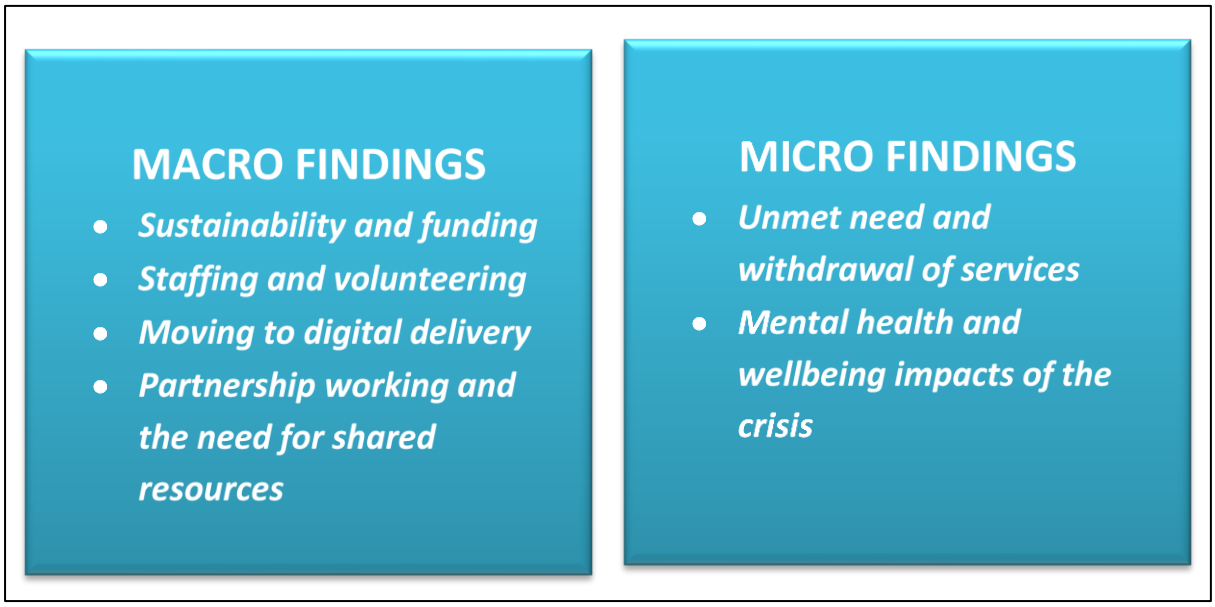
Executive Summary

As part of a COVID-19 Health Inequalities Impact Assessment (HIIA) for the North East, we conducted a rapid secondary analysis of qualitative community insight work conducted by VCSE sector organisations across North Cumbria and the North East to explore: (1) the health impact of covid-19 on at risk and vulnerable populations; and (2) the impact of the pandemic upon the VCSE sector and organisations supporting those groups. We received 26 responses from 21 organisations/projects across North Cumbria and the North East. We broke these findings down into:

- **Macro findings – organisational level**
- **Micro findings – implications for at risk and vulnerable populations**



Overall, the key findings were:

A. Most data focused on impacts at an organisational level rather than direct impacts upon at risk or vulnerable populations
B. At an organisational level, the most consistently reported impacts were greater reliance on local partnerships, sustainability, funding and staffing, and concerns over digital delivery of services – these impacts interlinked and overlapped.
C. For at risk and vulnerable populations, the implications of this were withdrawal of services / inequalities in digital access, loneliness and isolation and consistently reported impacts upon mental health, wellbeing and physical health behaviours.

Recommendations and next steps:

A. Funding is the most critical issue facing the VCSE sector. If they are to survive, many organisations will need financial support. Some may need shared infrastructures and long-term partnerships to be sustainable.
B. Positive outcomes included finding new ways of using technology to deliver services and increased partnership working and new collaborations.
C. Threats with the greatest potential to increase health inequalities are digital exclusion of those in most need of support; funding bodies prioritising Covid-19 at the expense of other areas of need; and withdrawal of services that are often the only source of support for the most vulnerable people.
D. The qualitative findings presented here will be triangulated with quantitative impact assessment work to identify evidence gaps or areas of best practice that warrant further qualitative exploration. This data – findings from sector-wide qualitative community insight work – was collected at the height of national lockdown or in the immediate summer period that followed. Further 'deep dive' work (focus groups, listening exercises, interviews) with a sample of organisations will allow additional, longitudinal exploration of the issues facing the VCSE sector and their beneficiaries as we move into Winter (and beyond) and a localised three-tier covid alert system.

Background

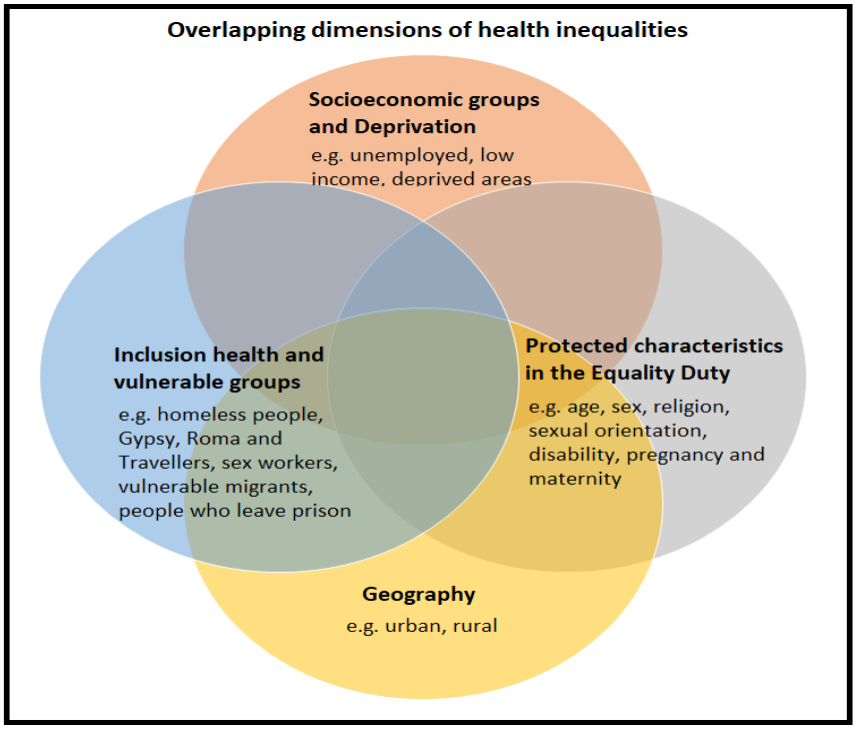
Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. A Health Inequalities Impact Assessment (HIIA) is a tool to assess the impact on people of applying a proposed, new or revised policy or practice. A HIIA prompts thinking about potential differential impacts based on income, employment, social and cultural status. Many policies, plans, proposals or decisions have the potential to impact on health and potentially widen health inequalities. By conducting a HIIA the potential impacts can be considered, and action taken to reduce those impacts (1). People are facing COVID-19 from uneven starting points and data is showing that the pandemic is disproportionately affecting some groups of the population more than others. A recent review conducted by PHE (2) showed that the largest disparity found was by age. Among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40. Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups. The review confirmed that the impact of COVID-19 pandemic has replicated existing health inequalities, and in some cases, increased them. This has been described elsewhere as a 'syndemic pandemic', where COVID-19 acts synergistically with – and exacerbates – existing socio-economic, geographical and ethnic inequalities (3).

There are clear reasons for giving priority consideration and support to those segments of the population that experience health inequalities. The burden of disease falls disproportionately on the most socio-economically disadvantaged and those with greater vulnerability to poorer health outcomes. We know that the North East experience some of the worst health inequalities in the country, in fact this was highlighted in the recent 'Marmot Review 10 Years On' where it stated that *"living in a deprived area of the North East is worse for your health than living in a similarly deprived area in London, to the extent that life expectancy is nearly five years less"* (4).

Who is at most risk of experiencing health inequalities?

Health inequalities are experienced by population groups across at least 4 dimensions, as illustrated in Figure 1 below. This is to be used alongside government guidance on protecting and shielding people who are extremely vulnerable to serious illness from COVID-19 on medical grounds who may also experience health inequity (found here). It also supports NHSEI's menu of evidence-based interventions and approaches for health inequalities, which is found here.

Figure 1

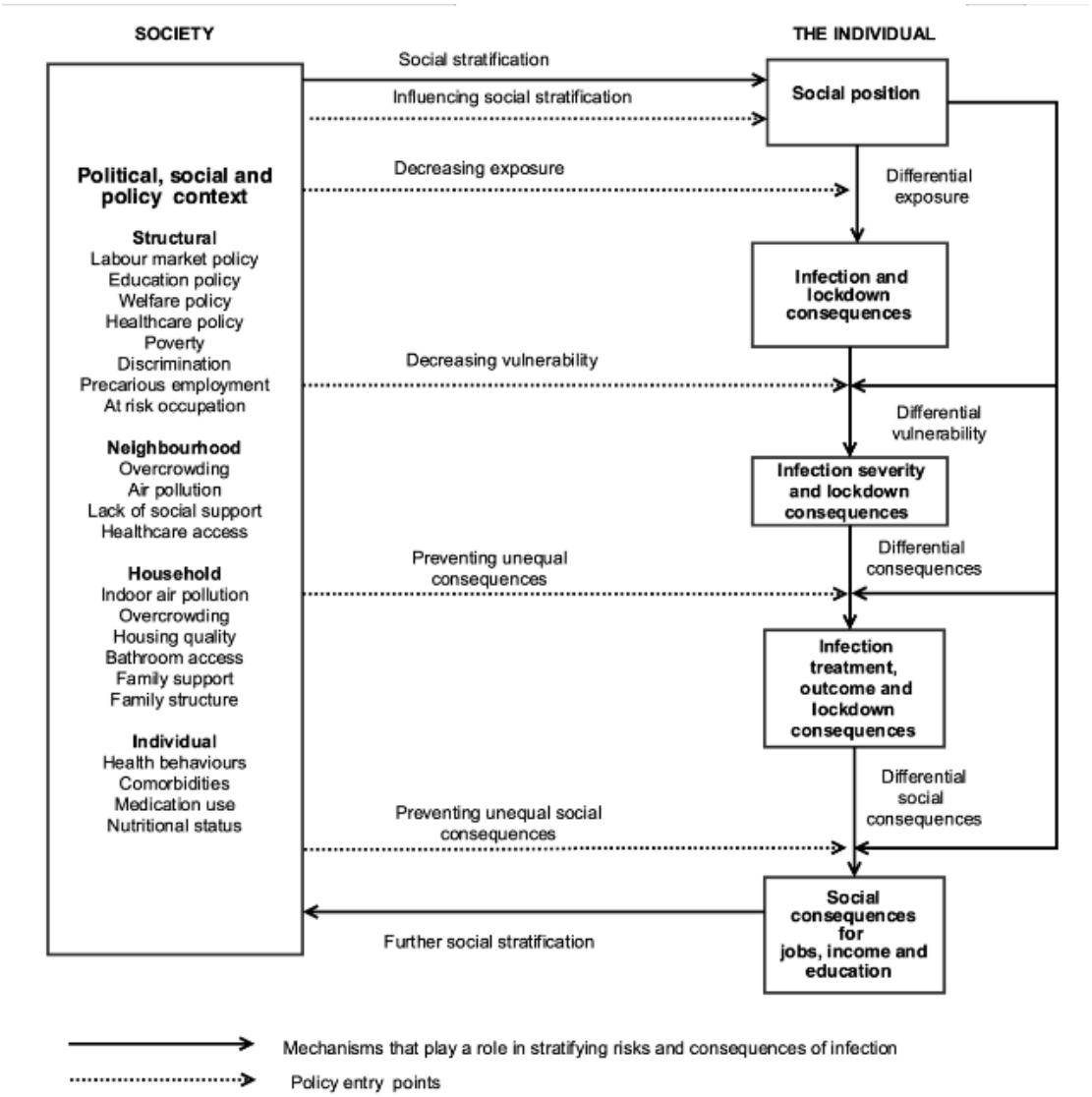


What do we already know about health inequalities?

To understand how COVID-19 related inequalities are generated in order to prevent them we need to learn from the existing wealth of knowledge on health inequalities. In a recent BMJ Opinion article (5) on COVID-19 and its impact on the most disadvantaged in society, the Diderichsen model (see Figure 2 below) was suggested as a framework for understanding how inequalities are likely to evolve during the pandemic, and when and where we can intervene to prevent the a further widening of inequalities. Authors of the BMJ article suggest that inequalities occur due to:

- Differential exposure – both to infection of COVID-19 and to the unintended consequences of government restrictions (inequalities in health outcomes associated with greater exposure due to where people live and work)
- Differential vulnerability – whether exposure to the virus leads to illness and complications may be impacted by factors which make a person more vulnerable (such as long-term health conditions and disability, capacity of health and social care systems)
- Differential consequences – of COVID-19 and the control measures (employment; insecure work, lack of ability to work from home, education; disruption to early child development and schooling)

Figure 2



Diderichsen's model to understand pathways to inequalities in Covid-19 infection and unintended consequences of lockdown (adapted from Diderichsen et al. 2001)

Focus on health inequalities

Yorkshire and Humber network public health network have developed some key concepts on COVID-19 and the response to support thinking about health inequalities (6). Their key messages include:

- COVID-19 is a new infectious disease. Initially everyone in the UK population is susceptible meaning they can catch the infection.
- Levels of transmission will vary across the country.
- The progress of the epidemic is unlikely to be linear and follow nice diagrams. We might get a second peak or even subsequent waves of infections but even if we don't, we are likely to get repeated cases and outbreaks.

- The epidemic is unlikely to end until we have a vaccine and/or effective drug treatment that is universally available across the world that eliminates the infection as a public health issue.
- 'Return to normal life', particularly for vulnerable people, in England is unlikely until we have a high level of herd immunity either through getting the virus or having a vaccine. How high does it need to be for COVID-19? Some are suggesting 60% but we don't know as it depends on many factors.
- COVID-19 harms can be direct or indirect. Some people will be affected by the disease itself, but many more people will be affected by the responses taken to manage COVID-19 and from the wider socio-economic effects.
- There are different types of health burdens from COVID-19 that could be experienced simultaneously by individuals, communities and health and soical care system. These burdens may also be experienced at different points in time by different places and systems.
- The harms from the response to COVID-19 and the wider economic impact will be greater, affect more people, last longer and disproportionally affect the most vulnerable in society
- We are in both a Response and Recovery phases for managing emergencies but that this is not a usual 'Recovery phase' and could be considered an Adaptive phase.
- It appears that social distancing measures are likely to be utilised in some form whilst COVID-19 is still causing disease until we have a vaccine or effective drug treatment

Covid-19 effects

As part of their work on health inequalities and COVID-19 Yorkshire and Humber Public Health Network have developed a helpful diagram that describes the many direct and indirect effects of COVID-19 (6). It also illustrates that the effects at the top of the pyramid will affect a small number of people whereas the effects nearer the bottom will affect many more people.

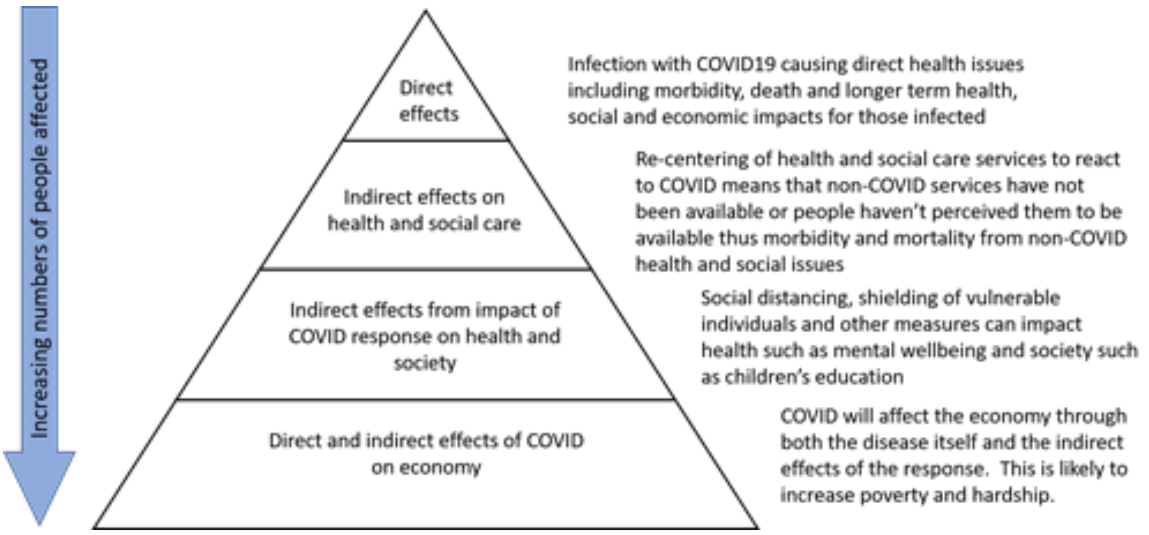


Figure 3: Developed by Yorkshire and Humber Public Health Network (6)

Timescales

Within a HIIA consideration needs to be given to the timescales. The direct and non-direct health impacts of COVID-19 are likely to be experienced over a range of time periods. These can be broken down into short, medium, long-term and impacts and issues that will fluctuate over time.

Time scales related to policies, behaviours, plans, proposals and decisions	
Short-term	Issues related to shielding and provision of food and necessities; domestic abuse and violence related to social isolation and stay-at-home measures; digital exclusion and impact on access to services, information and benefits; mental health support; access to and under-utilisation of health services.
Medium-term	Access to preventative services (e.g. screening, immunisations, weight loss services, smoking cessation services); issues related to changes in COVID-19 specific benefits (e.g., eviction ban, furlough income protections); income-related hardships due to extended recovery period from COVID-19.
Long-term	Economic impacts and health inequalities related to under-employment, unemployment and poverty.
Issues that will fluctuate over time	Flexibility necessary in policies to adapt to rapidly changing conditions. For example: Mental health issues related to social exclusion measures (i.e., periods of 'lockdown' or for shielded populations); digital exclusion issue during periods of school closures, service delivery changes, work-from-home provisions; access to services during periods of reduction in public transportation services.

Table 1: Developed by Yorkshire and Humber Public Health Network (6)

Aims and Objectives of the COVID-19 HIIA for the North East.

Aims

1. To understand the direct and non-direct health impact of COVID-19 on the population in the North East, including the implications of the response to the pandemic and identifying who are the most vulnerable and at-risk groups.
2. Assessment of the impact to inform health and social care recovery planning to support a focus on health inequalities and addressing wider social determinants.

Objectives

1. Use a health in all policies approach to identify existing and additional health inequalities as a result of COVID-19 and the associated response.
2. To make recommendations (at both organisational and partnership level) of mitigation actions to reduce health inequalities as part of the recovery process.
3. To identify positive consequences and impacts and make recommendations to build on new ways of working and support reducing health inequalities in the long-term.
4. To work with regional stakeholders to inform the assessment and recommendations.
5. To identify the current mitigation efforts that are being implemented across the NE, sharing good practice, avoiding duplication, provide support and identify gaps.

The underlying principle of this work is to ensure 'information for action'. It is proposed that work conducted as part of the NE HIIA can be used by decision makers to:

- identify actions to mitigate negative impacts and enhance positive impacts
- inform any continuation of, or adjustments to (including phasing out) services and policies
- support preparations for any second or third COVID-19 pandemic waves
- inform strategies for recovery and renewal.

Adapted from Wales HIA (7)

Limitations and challenges

It is acknowledged there are several difficulties in conducting a HIIA during the COVID-19 pandemic. Yorkshire and Humber Public Health Network have identified the following challenges:

- HIIA is usually used to assess 'one' policy and in COVID-19 we have multiple policies and other factors
- These multiple policies, behaviours, plans, proposals and decisions occurring or have occurred and that these occur simultaneously as well as concurrently making it hard to separate impacts
- These multiple policies, behaviours, plans, proposals and decisions are occurring at pace and at scale
- The concept of vulnerability is altered by COVID-19 with some people becoming newly vulnerable and others moving in and out of vulnerability
- There is little experience or evidence available to inform what the full range of impacts may be or how they may affect populations differently
- Resources, time and capacity issues may make it difficult to perform a HIIA during the COVID-19 pandemic
- Data and intelligence may not be available

Developed by Yorkshire and Humber Public Health Network (5)

Vulnerable groups

People may be considered vulnerable to COVID-19 related harm in several different and overlapping ways. The following diagram illustrates the potential vulnerabilities associated with the direct and indirect impacts of COVID-19.

Figure 4: Vulnerable and at risk populations

There are also several cross-cutting issues and themes to consider:

- Alcohol
- Drugs

- Problem gambling
- Tobacco
- Mental health and wellbeing
- Sexual health
- Screening and immunisations
- Healthy weight and physical activity
- Oral health
- MSK
- Domestic abuse

Links to other work

This North East Inequalities Impact Assessment will compliment other work being conducted in the region. A specific page on the C-WoRKs hub will be established to host and share this work and support collaboration with others. Learning from international, national, regional and sub-regional work will be shared through this group.
This work links with:

- the multi-agency mental health response and recovery framework that is being proposed by the Mental Health NENC ICS workstream
- work on unintended health impacts of COVID19 that NHSE/I are leading
- NENC ICS health Inequalities work through the Health Strategy Group and ICS workstreams
- links to health inequalities academic research through the new NIHR Applied Research Collaboration (ARC) in this region.

Qualitative Workstream

What did we do?

We conducted a rapid secondary analysis of qualitative community insight work conducted by VCSE sector organisations across North Cumbria and the North East. A templated email (see Appendix 1) was distributed to CABA leads across North Cumbria and the North East by VONNE/PHE in August 2020, requesting details of any community insight work (such as links to surveys, reports, focus groups, routinely collected data or anecdotal soft intelligence) undertaken with at risk and vulnerable groups focusing on either: (1) the health impact of covid-19 on these populations; or (2) the impact of the pandemic upon the VCSE sector and organisations supporting those groups. It is anticipated that capturing the issues the sector faces in continuing to provide support to their beneficiaries in this way will inform future planning and commissioning of services. Data were extracted into a standardised Microsoft Excel spreadsheet. Extracted data from each piece of evidence comprised: regional area, vulnerable group, study design, sample, key findings/themes and conclusions or

recommendations offered. These data were subsequently analysed thematically. Descriptive themes were compared to identify patterns, similarities and differences in the data. Data extraction, coding and analysis were undertaken by SS, VM and JW. Themes were discussed and challenged at regular project meetings. Qualitative findings presented below will be triangulated with quantitative impact assessment work to identify evidence gaps or areas of best practice that warrant further qualitative exploration – feedback from the sector suggests 'survey fatigue' therefore other ways to engage are being explored such as listening exercises, workshops or focus groups.

What did we find?

We received 26 responses from 21 organisations/projects across North Cumbria and the North East. Appendix 2, Table 1 illustrates the characteristics, outcomes, and recommendations from each piece of data received. Overall, the key findings were:

A. Most data focused on impacts at an organisational level rather than direct impacts upon at risk or vulnerable populations
B. At an organisational level, the most consistently reported impacts were greater reliance on local partnerships, sustainability, funding and staffing, and concerns over digital delivery of services – these impacts interlinked and overlapped.
C. For at risk and vulnerable populations, the implications of this were withdrawal of services / inequalities in digital access, loneliness and isolation and consistently reported impacts upon mental health, wellbeing and physical health behaviours.

Recommendations and next steps:

A. Funding is the most critical issue facing the VCSE sector. If they are to survive, many organisations will need financial support. Some may need shared infrastructures and long-term partnerships to be sustainable.
B. Positive outcomes included finding new ways of using technology to deliver services and increased partnership working and new collaborations.
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We now go on to present the findings in more detail (see Figure 5 below) – divided into two sections:

- **Macro findings – organisational level**
- **Micro findings – implications for at risk and vulnerable populations**

Figure 5: Overview of key findings

1. **Macro findings – organisational level**

1a. Sustainability and Funding

The most consistently expressed concerns were financial – covering the costs of wages and critical bills *now*, and worrying about longer-term sustainability and the prolonged impact of loss of income:

> "*With the charity unable to fundraise in the normal way, how we sustain income levels without eating too much into reserves*".

Most organisations have seen a massive increase in demand coupled with increased costs, reductions in funding and cancelled events/closure of premises and services. One stakeholder described this as a 'twin storm', leaving staff with a massively increased workload and equipment need post-pandemic without the staff, equipment, or funding needed to cope with this extra demand:

> "*Our concerns are around sustainability due to the increase of people needing support with their increased anxiety, changes within their living*

structures……..living in difficult family situations. As time goes on this is only going to get worse".

A third of VCSE organisations surveyed by VONNE expected to lose more than 50% of their income in the quarter April to June 2020, with small/medium organisations (those with turnover less than £500k) expecting the biggest income reductions:

"*No income. Mothballed the hall. Turned off the heating."*

Most impact has been felt on earnings/retail (lack of footfall, social distancing measures) and fundraising income, with investment income considered to have been impacted upon the least. Several organisations reported that the NHS refers/relies on charities to do a lot of aftercare work and to support patients and their families. Covid-19 has halted and disrupted a lot of fundraising on which North East charities rely. For example, covid-19 resulted in the cancellation of, and poor attendance at, fundraising events prior to lockdown, with some people feeling too frightened to attend due to the high-risk nature of the situation. Further, other stakeholders identified specific concerns about the diversion of fundraising to charities dealing specifically with covid-19, with many individuals and companies instead choosing to support covid-19 related campaigns and initiatives, in response to the pandemic emergency:

"*We are concerned that the funding we need will continue to be diverted.*"

Only one third of organisations surveyed by VONNE have successfully secured covid-19 funding, with 40% of organisations at risk in the shorter-term as they either hold no reserves, or only enough to cover three months' core costs. Similarly, survey findings from the VCS Assembly indicated significant income loss between April and June 2020 in a period when fundraising would normally take place:

"*Having enough funding to operate over the winter. Summer profits from functions supports the business.*"

Half of respondents had only six months' reserves indicating financial distress, and over 40% had been unable to operate their services at all with a significant impact on beneficiaries:

"*Financial viability if we lose service users as a result of the virus – as well as the emotional impact on everyone. Planning for the recovery period…*"

Thus, some smaller organisations reported concerns that, whilst there will be an increased need for their specialist expertise, they may not be in a position to provide it. Nevertheless, 65% of those surveyed by VONNE rate the response, and flexibility shown, by funders to be

good or very good. Moving forward, stakeholders are keen that funders continue to streamline and simplify application processes, be flexible, responsive and long-term in their approach:

> "*Good response generally. Still some funders in the NE have directly forwarded money to known recipients but not opened it up to a wider offer. There needs to be more focus now on post-Covid resilience funding.*"

1b. Staffing and Volunteering

Findings from VONNE indicate that the VCSE sector's capacity is severely limited at the current time, with 53% of the workforce not operational (due to furlough and/or redundancies) and 75% of volunteers unable to support their organisations. Reduced capacity is likely to continue, with organisations expecting an average drop in staffing capacity by a third due to reduced income levels. This has led to widespread loss of experience and expertise. Some organisations reported an expansion in volunteer numbers to mitigate demand. An expansion in volunteering (predominantly through partnerships and the involvement of mutual aid groups – see 'partnership working' below) is a potential benefit to the sector. Nevertheless, one larger organisation reported that the influx of this number of volunteers, complying with minimal checks and segregating DBS and non-DBS has put enormous strain across the entire organisation and incurred substantial extra cost.

Stakeholders also reported concerns about the physical health of staff and volunteers. Some concerns related to staff and volunteers needing to isolate or shield:

> "*Our volunteers are in the vulnerable age-groups – self-isolating*"

However, organisations also indicated that they were in need of practical advice relating to PPE and managing social distancing within buildings, organisational and business planning support, financial advice, legal and governance support:

> "*Advice and guidance on how we can operate post Covid-19...we need guidance and clarity on when and how we can safely start to open and provide services again.*"

In addition to physical health, most organisations outlined concerns about the impact of the crisis on the mental health and wellbeing of staff and volunteers:

> "*Mental health of team especially managers who are taking a real battering. Very long lasting mental health issues for members.*"

The crisis has led to adaptations to processes and services, that staff have needed to learn at pace, likened to operating a 'call centre model' by one stakeholder. Moreover, staff are typically working beyond contracted hours; with many organisations moving to 7-days a week openings/no Bank Holiday closures:

> "*underlying concern across the organisation that once the pandemic reduces its impact on society the efforts of* [name of organisation] *will be forgotten and the transitionary period to normality may not take into account current levels of fatigue.*"

1c. *Moving to Digital Delivery of Services*

Most organisations reported that their offices are closed in line with government guidance, with support offered by telephone and online; some stakeholders are developing online tools and apps. Telephone support included befriending calls, which was expanded in some areas through the region-wide Keeping People Connected project to also include text/email support and online social networking. Organisations mainly offering face to face support have had to close altogether, furlough staff, or provide signposting to other local services. Nevertheless, stakeholders reported both positives and negatives in relation to digital provision. Thus, staff at one small Middlesbrough-based organisation felt that they had adapted well, continued to work productively as a 'remote' team, have had the opportunity to develop new skills and reach new clients. They referenced their organisational goal of addressing loneliness and felt that valuable connections could also be developed remotely.

However, for many organisations, the variety of services on offer has reduced substantially whilst demand for services that allow people to self-isolate, retain skills and feel valued continues to grow. Several organisations that provide educational, creative or therapeutic activities have therefore begun engaging with beneficiaries via online provision of tutorials/classes and activity packs where possible. Some organisations were able to adapt in this way due to robust IT systems and business continuity plans. Others, however, reported beneficiaries lacked access to suitable technology (for example smart phones or tablets) in order to take part in services (more on 'digital inequalities' below). One organisation estimated that 20% of its beneficiaries do not have an email address, and another described this as a 'two tier system', whereby some of the most vulnerable members of the community are being excluded. Some organisations have been able to provide tablets temporarily, but not all have access to such equipment. For example, one small Middlesbrough-based organisation provided digital devices to older people motivated to use the Internet but unable to afford a device, identifying that devices improved older people's ability to interact socially during lockdown.

Further, the move to home working has come at a significant extra cost to some staff members. Specifically, where staff are living in shared accommodation they are having to

renegotiate rental agreements to secure extra workspace in order to continue to work and provide support to the community. Also, some have needed to secure or upgrade their internet, buy computers or smartphones, and software:

"*We don't have enough lap-tops to enable staff to work from home*…."

Other organisations highlighted that there are certain services that cannot be offered remotely, and that virtual support cannot always replace the need for face-to-face meetings or treatment. For example, one stakeholder reported that a reliance on online interaction has resulted in the loss of nuance in client engagement. When dealing with complex individuals the removal of such subtlety in interaction can result in not picking up clues and danger signs. Respondents reported this is resulting in clinical signs being missed. Further, service providers for individuals with sensory problems have reported that interaction with these individuals cannot be done using virtual tools due to their disability.

1d. Partnership working and need for shared resource

Many organisations indicated high levels of collaboration and emphasised the importance of local partnerships, with local authorities and other organisations, throughout the crisis. Most organisations would like to see this partnership model continue long-term ensuring that the VCSE sector has a 'seat at the table' to engage and input into restart and recovery plans with statutory agencies:

"*Building and supporting partnership working within the sector*"

Further, stakeholders also identified the need for a shared logistic infrastructure or co-ordinated services to share resources where needed (referred to by some as 'crisis infrastructure'). For example, one large organisation reported key partnerships with local taxi companies and cafes, volunteer chefs and mutual aid groups, the latter of which are now embedded in volunteering and/or core service delivery across a number of different organisations (see 'discussion and recommendations' for further reflections on the role of mutual aid organisations).

2. Micro findings – implications for at risk and vulnerable populations

2a. Unmet need and withdrawal of services

A survey conducted by VONNE as part of this rapid review indicated that 82% of service providers stated that social distancing measures have had a significant impact on their ability to deliver services. Of those, 39% have not been able to operate at all. Thus, according to this survey, almost 400k individuals are no longer receiving, or are receiving a significantly reduced service, from the 269 VCSE organisations that support them. Currently, the groups with the highest levels of unmet need are children and young people, older

people, and people with disabilities, including learning disabilities. These are also the groups most likely to be unable to access services either online or by telephone:

> "*When the youth clubs re-open we expect to be dealing with a lot of safeguarding and mental health issues.*"

Reflections from young people indicated that during lockdown isolation from their friends and family was a significant issue. They also reported missing school/teachers, weekend routines and having other children to play with. Further, they found being together (with family) in close proximity at all times was sometimes quite stressful:

> "*Since my school shut down, me, my Mam and my Stepmam have been working from home on the dining room table. We have also been getting stressed and we've been struggling with our work.*"

Withdrawal or reduction in formal services has also led to significant burden for those caring for people with learning disabilities, mental and physical health problems and older people. Lockdown has had a detrimental effect on carers' health, wellbeing and finances, with interdependency a key concern, resulting in carers needing care and respite themselves. However, some are struggling to access online information and support. Most carers would welcome resumption of services, although some would be wary of the person in their care attending face-to-face sessions. Services adapting to the pandemic by moving to online and/or telephone provision reflected on the implications of this for other marginalised or excluded groups:

> "*Why does everything have to be online? That's one of the problems with this. If you can't read and write it's hard enough but then everything uses technology and you can't use that either. I like just to have you tell me what's going on."*

Hearing impaired beneficiaries raised concerns about PPE, not seeing appropriate healthcare professionals and about communication/telephone consultations:

> "*Clear PPE rather than face masks as I could not lip read and it was difficult for them to remove while treating patient.*"

Meanwhile, stakeholders working with visually impaired individuals highlighted concerns that members will feel isolated and unable to socialise within the community due to their vulnerabilities. Moreover, in some cases ongoing health conditions may exacerbate these feelings of isolation as they need to shield during the pandemic. Furthermore, previous methods for keeping up to date with community, health and general information have

ceased as the local audio newspaper channel stopped operating just before lockdown effectively breaking another link for this community group to stay informed and connected.

Concerns were also raised relating to BAME communities. Those working with asylum seekers reported isolation, poor accommodation and overcrowding, lack of money, social networks and fear of being arrested if leaving the house. EU citizens were also highlighted as particularly vulnerable – access to universal credit is an issue as is needing to apply for settled status. Further, BAME young people discussed experiencing hate abuse online, crowded households, no outlet for pressures, fear that parents may be affected due to working in care professions. Similarly, one organisation based in Darlington identified that the local community has a large BAME population including a large proportion of the Bangladeshi community or refugees unable to speak English as their first language. During the pandemic local councillors and healthcare professionals have regularly raised concerns over a lack of accessible information about the virus via the NHS or within the community for those where English is not their first language. Other stakeholders have suggested that lack of clarity in government messaging may exacerbate this issue, with covid-19 health messages proving to be too complex or not in plain English. For many members of the BAME population, cultural barriers already mean that communities might not engage with local services so any information that might be available could be missed. IT illiteracy is also high in older BAME populations, potentially leaving them less likely to use the internet to access information, which makes them particularly hard to reach.

2b. Mental Health and Wellbeing Impacts of the Crisis

Some organisations have reported an increase in issues like domestic violence, drug abuse, gambling and debt and are working closely with beneficiaries and other agencies. During Covid-19, one smaller organisation recorded a 13% increase in outreach referrals and a 61% increase in 'short term contact' defined as ‘one off’ or shorter interventions that do not require (or already have) a full Risk Assessment completed. Meanwhile, a larger organisation in Sunderland found that 53% of survey respondents stated their mental health has been negatively impacted to some extent during the pandemic. Of those who responded, 41% had decreased levels of exercise, 36% were smoking more, 22% were drinking more alcohol and 41% had gained weight. Almost all organisations identified that withdrawal of formal services has resulted in loneliness and isolation, with a lack of attention sometimes being paid to mental health and anxiety due to an official focus on physical health:

> “*Potential increase in mental health trauma as and when this crisis gets worse and the impact becomes more evident.*”

Thus, a large organisation in Gateshead reported that their mental health support service was under incredible strain, with an increase in supporting those who are threatening

suicide from 3 per month to 5 per week. Further, themes most commonly discussed by participants in the region-wide Keeping People Connected project were anxiety, followed by loneliness, isolation and mental health concerns:

> *"Finally, some support. I feel like me and my son have been left high and dry and I'm grateful. We are struggling for food and my son is struggling with his mental health. We didn't know who to turn to, so you phoned at just the right time"; "I'm worried about the long weekend –I'll hardly see anyone. It is like I don't exist."*

Conclusions and Recommendations

Overall, the key findings from this impact assessment suggest that:

A. Most data focused on impacts at an organisational level rather than direct impacts upon at risk or vulnerable populations
B. At an organisational level, the most consistently reported impacts were greater reliance on local partnerships, sustainability, funding and staffing, and concerns over digital delivery of services – these impacts interlinked and overlapped.
C. For at risk and vulnerable populations, the implications of this were withdrawal of services / inequalities in digital access, loneliness and isolation and consistently reported impacts upon mental health, wellbeing and physical health behaviours.

Many organisations reflected on the need for shared 'crisis' infrastructure and on the importance of local partnerships. In particular, some organisations had received support from mutual aid organisations. Mutual aid networks (such as https://covidmutualaid.org) have developed across the country in response to the COVID-19 pandemic. There are now thousands of grassroots groups, and social media sites, such as Facebook, WhatsApp and Twitter, have been used extensively to mobilise, communicate, find volunteers and distribute aid. Approximately two million people in the UK have joined local support networks on Facebook, with the site 'Nextdoor' experiencing a 90% rise in membership since the crisis began. Whilst only a small amount of research has explored community aid responses to the pandemic, findings from two large surveys suggest an expansion in volunteering trends – in itself, a potential positive for the sector (see section above on 'volunteering'). Pre-pandemic, females, married people and those with higher educational levels and income were more likely to take part in voluntary work (8). A wider range of factors have predicted volunteering during the pandemic including older age, being of non-white ethnicity, not living with a spouse, living with others, living in a rural location, not being employed, being a keyworker and having diagnosed health conditions (9). Speculatively, broadening volunteer profiles may lead to greater diversity in the background

of volunteers, in turn, leading to a volunteer 'community' which is both socio-demographically diverse and more representative of the communities they serve.

It is important to acknowledge the hard work that has gone into providing this data under challenging circumstances. Inevitably, data collated was variable and not always comparable or directly related to the impact of covid-19. Further, the qualitative data synthesised in this report represents a snapshot in time, and only from organisations that were able to respond to our request for data at rapid pace. The covid-19 crisis will not fade any time soon and the VCSE sector will face challenges for a long time to come. Data presented here was collected at the height of lockdown or in the immediate aftermath. Thus, there is a need for longer-term community insights as we approach winter (and beyond into 2021) and as we approach a new three tier localised covid alert system. Drawing these points together, further 'deep dive' exploration will allow us to more systematically collect data, or explore potential gaps/omissions from this rapid report. Overall, our recommendations and next steps are therefore:

A. Funding is the most critical issue facing the VCSE sector. If they are to survive, many organisations will need financial support. Some may need shared infrastructures and long-term partnerships to be sustainable.
B. Positive outcomes included finding new ways of using technology to deliver services and increased partnership working and new collaborations.
C. Threats with the greatest potential to increase health inequalities are digital exclusion of those in most need of support; funding bodies prioritising Covid-19 at the expense of other areas of need; and withdrawal of services that are often the only source of support for the most vulnerable people.
D. The qualitative findings presented here will be triangulated with quantitative impact assessment work to identify evidence gaps or areas of best practice that warrant further qualitative exploration This data – findings from sector-wide qualitative community insight work – was collected at the height of national lockdown or in the immediate summer period that followed. Further 'deep dive' work (focus groups, listening exercises, interviews) with a sample of organisations will allow additional, longitudinal exploration of the issues facing the VCSE sector and their beneficiaries as we move into Winter (and beyond) and a localised three-tier covid alert system.

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Appendix 1: Email to CABA leads

Dear CABA Leads

COVID-19 Health Inequalities Impact Assessment for the North East
We are working with our North East & North Cumbria ICS (Integrated Care System), Health Researchers, and Public Health colleagues to support a **COVID-19 Health Inequalities Impact Assessment for the North East.** The aims of this Impact Assessment are to:

1. Understand the direct and non-direct health impact of COVID-19 on the population in the North East, including the implications of the response to the pandemic and identifying who are the most vulnerable and at-risk groups.
2. Assess the impact to inform health and social care recovery planning to support a focus on health inequalities and addressing wider social determinants.

It is vital that we reach our vulnerable and at risk groups to gain some insight as to both the direct and in-direct impact of COVID19 on their lives so we can inform health and care 'recovery' planning and commissioning, and ensure we don't overlook those most disadvantaged and affected by the negative impact of COVID19.

It is also useful to understand the impact on the VCSE sector organisations supporting those groups so that those planning and commissioning services can be aware of the issues the sector faces in continuing to provide support to their beneficiaries.

With this in mind, we wondered if you were involved in or aware of any community insight work with at risk and vulnerable groups in your local areas, and if so, if you would be willing to share this with us to inform our work. This could be links to surveys, reports, findings from focus groups, 1:1 calls, or anecdotal soft intelligence. Also, if you have any suggestions for organisations we could contact who may have some data or may be interested in doing some community consultation, please let me know. If easier, I can give you a call to discuss further. Apologies for the tight timescale but if you can send any information you have access to or get in touch to arrange a call by next **Wed 2 Sept** that would be great.

Appendix 2, Table 1: Project Characteristics and Key Findings

Organisation	Vulnerable Group	Study Design/Sample Type of Evidence	Findings	Conclusions and Recommendations
Northumbria Cancer Patient and Care Group Northumberland	Clinical Complexity	Comments/quotes from survey and engagement events 350 responses from patients and carers	**What worked well:** Staff central to positive experiences, high levels of satisfaction with medical care and diagnosis, lack of data on aftercare and emotional support. **Where could care be improved?** Lack of emotional support/information after diagnosis, during treatment and afterwards ("I felt so lost and alone after treatment I tried to commit suicide", "I felt like I was just drifting") **Where are the gaps?** Mental Health: whilst staff dealt with physical needs well, patients often felt their emotional needs were left behind with little time to appreciate their mental health. Patients and carers had difficulty accessing transport services, financial advice/support, and would have benefitted from access to more information and signposting from healthcare professionals. **What services would you like to see in your area?** Transport ("A community bus service"), support ("Local support groups where patients and carers can meet others in the same situation"), mental health services ("…including short term end of life mental health support") and awareness / information / advice ("More awareness about what services are available would have prevented years of feeling alone and struggling") **However, overall, report data does not appear to be specifically linked to covid-19 impact. One section highlights the following:** • **covid-19 resulted in cancellation of an event and negatively affected attendance at two events prior to lockdown. Some people felt too frightened to attend due to the high-risk nature of the situation.** • **The NHS refers/relies on charities to do a lot of aftercare work and support patients and their families. Covid-19 has halted and disrupted a lot of fundraising that NE charities rely on.** • **As a result, charities are struggling to obtain funding and cannot provide as many services ultimately meaning patients will suffer.**	Need for holistic support throughout full cancer pathway. Covid-19 may have halted much of the aftercare/emotional support that patients receive via charities. Investment into a robust mental health cancer service structure, which is accessible to cancer patients, their carers and their families from diagnosis, through treatment and beyond, may mitigate some of this impact.
Age UK Gateshead	Older People	Routinely collated service data. Types of data included:	Service offer variety has shrunk substantially however service demand which allows people to self-isolate, retain skills and feel valued continues to grow. Delivery of virtual classes (such as Active Age fitness) via zoom, with	Full service withdrawal after the pandemic would be impossible without causing real harm. The organisation will find itself in a financially weakened

		• outgoing/incoming calls • enabling/specialist services • staff/volunteer numbers • financial data	participation level increasing substantial over the last 6 weeks (first 6 weeks of lockdown). Info and Advice provision closed and process restructured to mirror those of a contact centre. Enabling services (e.g. support with prescriptions), hot meal provision, shopping services and food parcels supported by key partnerships (mutual aid organisations, Staiths Cafe, volunteer chefs and Dean Taxis). IMC/IMH mental health support service under great strain; increase in supporting those who are threatening suicide from 3 a month to 5 a week. This section of the organisation is resource intensive and only delivered due to funding from the Police & Crime Commissioner (PCC). NODA has been impossible to deliver within the community or hospital setting outside those who are at the end life with a cancer diagnoses; have effectively lost a day centre to COVID-19. The service now has a waiting list, however due to the nature of need, the organisation is unable to incorporate partner provision. Currently 3 staff and 8 volunteers are providing support and talking therapy to a growing client base - continue to support 303 individuals within community living with a cancer diagnosis. Volunteering: 87 (of 147) volunteers had to self-isolate which reflects the age of volunteer. Within first week of lockdown, volunteer base increased to 529 from direct applications; later joined by 17 mutual aid groups taking the volunteer number to 2149. Due to relaxation of GDPR, Age UK were able to open up the organisations CRM providing access to 27 Mutual Aid organisers within a restricted area of service requests, this enabled full community delivery to meet service demand. The influx of this number of volunteers, complying with minimal checks and segregating DBS and non-DBS has put enormous strain across entire organisation and incurred substantial extra cost. Staffing: 37 staff (10 are furloughed). Staff typically work beyond contracted hours; have also moved to 7-days a week/no Bank Holiday closures - underlying concern across the organisation that once the pandemic reduces its impact on society the efforts of Age UK Gateshead will be forgotten and the transitionary period to normality may not take into account current levels of fatigue. Finance: Significant loss of retail income, client contributions, funder withdrawals and increased service costs linked to community based delivery.	position unable to subsidise provision as it currently does. The core team are currently looking at a mix of community based delivery and charity based support in order to ensure a level of continuity. A recent mapping exercise has shown Age UK Gateshead has full borough coverage at street level and is therefore well placed to develop community based provision, beyond a hub style mechanism with a focus on street level provision.

Blue Stone Consortium Newcastle, Gateshead	Poor Access to Care	Consultation with third sector organisations about their service provision. Created a map of resources to enable LAs to match residents with their support needs, followed up with further rounds of consultation with additional third sector organisations. Data collected from 45 organisations on: whether they are still providing a service; how have they adapted/what is their adapted offer; new users/existing users only; barriers to provision; impacts on local health and care system. Research was also undertaken looking at each organisation's website. Organisations were contacted by telephone where possible and email to gather further information not readily available on their websites.	**Service Provision:** Most organisations' offices are closed in line with government guidance, with support offered by telephone and online. Some organisations reported robust IT systems and business continuity plans to enable them to do this. Some organisations offering mainly face to face support have had to close altogether and have had to furlough staff. Others are signposting to other local services, where they are unable to provide assistance. A number of organisations that provide educational, creative or therapeutic activities are engaging with beneficiaries through the provision of online tutorials/classes and activity packs where possible. Some smaller organisations are concerned that whilst there will be an increased need for their specialist expertise, they may not be in a position to provide it. **Reach/Technology:** Some organisations reported difficulty reaching beneficiaries in rural areas. Lack of technology has been reported as an issue, where beneficiaries don't have access to smart phones or tablets to take part in services. One organisation estimated that 20% of its beneficiaries do not have an email address. Some organisations have been able to lend tablets but not all have access to equipment and are requesting small grants to enable people to stay connected. **Extra Services:** Some organisations are reporting additional/adapted service provision including pastoral care for those in distress and provision of food parcels for vulnerable residents. Pastoral care extended to staff and volunteers affected by office closures and related isolation. **Increased Need:** Some organisations already report an increase in issues like domestic violence, drug abuse, gambling and debt and are working closely with beneficiaries and other agencies. Many others (including some who are under threat) are anticipating major increase in mental health and wellbeing need and related trauma. **Funding:** Whilst most funders and commissioners are being supportive and flexible, some organisations reported concern about funding, particularly in relation to funders' flexibility with targets. European Social Funding was cited as a particular example. Organisations reliant on income from service delivery/trading are looking at emergency funding to ensure their existence once the crisis is over.	None offered.
Vonne	General	Two online surveys	**NE Wide:**	**NE Wide:**

Region Wide		NE Wide: launched 22nd April 2020, open for 12 days, closed 9am on May 4th. 404 responses following removal of duplicates / responses that were not from VCSE organisations. Cumbria Only: distributed to organisations within the Cumbria Voluntary Community and Social Enterprise (VCSE) Sector. Initial closing date for completion was 29th March 2020. 208 responses following removal of duplicates/anonymised responses.	A third of VCSE organisations surveyed expect to lose more than 50 per cent of their income in the quarter April to June 2020, with small/medium organisations (those with turnover less than £500k) expecting the biggest income reductions. Most impact felt on earned and fundraising income, investment income was considered to have been impacted upon the least. The VCSE sector's capacity is severely limited at the current time, with 53 per cent of the workforce not operational and 75 per cent of volunteers unable to support their organisations. Reduced capacity is likely to continue, with organisations expecting an average drop in staffing capacity of a third because of reduced income levels. 82 per cent of respondents stated that social distancing measures have had a significant impact on their ability to deliver services. Of those, 39 per cent have not been able to operate at all. Almost 400k individuals are no longer receiving, or are receiving a significantly reduced service, from the 269 VCSE organisations that support them. The groups with the highest levels of current unmet need are children and young people, older people, and people with disabilities, including learning disabilities. These are also the groups most likely to be unable to access services either online or by telephone. Only a third of organisations have successfully secured Covid-19 related funding.40 per cent of organisations are at risk in the shorter-term, as they hold no reserves or only enough to cover three months' core costs. Despite this, only 13 per cent of respondents consider it likely or very likely that their organisation will close as a result of Covid-19.It could be that they are expecting the impact to be short-lived, and/or that their organisations will bounce back once lockdown restrictions begin to be eased. Some respondents asked for practical advice relating to PPE and managing social distancing within buildings, organisational and business planning support, financial advice, legal and governance support ("Advice and guidance on how we can operate post Covid-19...we need guidance and clarity on when and how we can safely start to open and provide services again."). 65 per cent of those surveyed rate the response by, and flexibility shown by funders, to be good or very good. Respondents request that funders continue to streamline and simplify application processes, and to be flexible, responsive and long term in their thinking ("Good response generally. Still some funders in the	Many opportunities have emerged from the Covid-19 crisis, including more innovative and digital ways of working, new collaborations and partnerships, and an openness and willingness to respond effectively. It's important the sector is encouraged and supported to reflect and build upon this learning moving forward. However, not all organisations, VCSE staff and volunteer teams have had the capacity, confidence or access to kit or software to be able to respond in this way, and continued support will be required for them to do so. Many organisations have identified the need to tackle digital exclusion among beneficiaries, stating it is often the individuals most likely to be at high risk of Covid-19, or that are furthest from accessing services, impacted most by this. Urgent solutions must be developed or the digital and inequality divide will widen. Statutory agencies including the integrated care system, local authorities, combined authorities and Local Enterprise Partnerships must ensure the VCSE sector has a 'seat at the table' to engage with, and input into, restart and recovery plans. The sector has a key role to play, in partnership with statutory agencies, to develop collaborative solutions within recovery plans. **Cumbria Only:**

			NE have directly forwarded money to known recipients but not opened it up to a wider offer. There needs to be more focus now on post-Covid resilience funding"). Survey indicates high levels of collaboration and partnership working with local authorities and other organisations; most would like to see this partnership model continue long-term. Many organisations still focusing on immediate aftermath of lockdown and its impact on staff, volunteers and beneficiaries, rather than the short/medium term issues facing them. Organisational support and development issues such as financial management, strategic planning, contingency planning, governance and legal support or advice around mergers and closure, were generally rated much lower for most respondents at this stage. **Cumbria Only:** *Immediate Challenges:* 1. Loss of income – from rental of venues, delivery of paid-for activities/services/products, cancellation of fund-raising events and activities. 3. Losing contact with service-users due to prolonged closure and/or reduction/change of activities and services – noted strongly from youth groups who think it might be difficult to re-engage post-crisis. 4. Needing more volunteers to replace those who are ill and/or isolating. 5. Changing to online support rather than face-to-face – sometimes less effective or not as appropriate. Also concern that some service users are not digitally connected. 6. Lack of food donations (particular issue for Food Banks, which are having to buy food.) 7. Keeping employed staff and volunteers safe – including concern about lack of PPE. 8. Perceived lack of leadership from Cumbria County Council. Need for some organisation to provide co-ordination. 9. Not being able to meet the contractual terms of grants – e.g. not able to deliver funded activities. 10. Lack of cashflow to cover on-going costs. 11. How to maintain facilities in good condition – specifically halls, sports grounds, playgrounds, public toilets (which are closed but still require maintenance).	The most consistently expressed concerns are financial – covering the costs of wages and critical bills now, and worrying about the impact of loss of income. These concerns are closely followed by learning how to deliver services and stay in touch with both service-users and staff/volunteers using digital and social media platforms. Longer term, organisations have worries about sustainability – not only due to financial insecurity but also because they may have lost their user-base.

			12. Keeping hold of experienced staff. 13. How to restart after shut-down. *Longer Term Challenges:* 1. Re-engaging with users, getting people to come back to activities, to use halls etc. 2. Long term financial insecurity due to eating into reserves, lack of income, inability to fund-raise. 3. Length of time required to recommission programmes of activity. 4. Maintain morale if this crisis goes on for a long time. 5. Retaining new volunteers. 6. Mental health impact of the crisis on both those delivering the services and on users.	
MECC Gateshead	General	Overview report focusing on how the MECC approach has challenged inequalities. Includes one case study (Skills4Work). No further information about sample.	Skills4Work have been introduced to key workers at the QE. This has enabled a workshop from Infection Control to teach the young adults about hand hygiene in a fun and interactive way that they now remember.	None offered.
Wearside Women In Need Sunderland	Risk from indirect harm	Routinely collated service data No further information about sample	• Increase in women with complex needs – notably single women with ranging mental health needs and substance misuse issues. Complex needs not manageable in a general purpose refuge (WWiN were meant to be opening a complex needs refuge in April but was put on hold due to Covid-19). • Need multi-agency approach to meet the specific needs of the women, particularly around mental health. • Demand for refuge services particularly during lockdown. • Had to support the local authority and housing providers to house the homeless population during the initial response phase to Covid-19 • Referrals from Police and Children's services were lower during lockdown • Saw increase in referrals for refuge places from neighbouring authority areas (Newcastle, North Tyneside, Northumberland) • 40% of women accessing the service have disabilities – shows a high vulnerable group entering risky relationships and spiralling complex needs • Bed blocking is an ongoing issue but WWiN are working proactively to increase throughput	None offered.

			• Court stopped sitting during Covid which has meant there is a backlog in waiting for court outcomes meaning delays in moving some clients on • 13% increase in outreach referrals during covid-19; 61% increase in 'short term contact' during covid-19 - defined as 'one off' or shorter interventions that do not require (or already have) a full Risk Assessment completed. Many are closed cases checking in, or one off advice sessions from the helpline.	
Healthwatch Darlington	Clinical complexity: Shielding; Increased risk of transmission: High risk behaviours (smoking, drinking)	Online survey gathering views since 7th July 2020; engaging with service users via email, telephone and social media messaging. Early Indicator Summary Report No further information about sample.	**Hearing Impairment**: Concerns raised about communication, telephone consultations, PPE, choice, accessibility for deaf/hearing impaired patients and not seeing the appropriate healthcare professional. • "Clear PPE rather than face masks as I could not lip read and it was difficult for them to remove while treating patient." • "I wear hearing aids and found it very difficult hearing what the doctor said on the phone consultation. I did ask him to speak louder but he didn't." • "I tend to prefer information to be sent to me by email or text message, as that's better for me, due to me having limited sight, and also helps to save the planet as not so much paper is being wasted." **Visually Impaired**: concerns that members will feel isolated and unable to socialise within the community due to their vulnerabilities and in some cases ongoing health conditions which means they need to shield during the pandemic. A local audio newspaper channel acted as way to stay up to date with community, health and general information had stopped operating just before lockdown which means another link for the community group to stay up to date with information has been missing. **Digitalisation**: information for those who are not on the internet either from NHS or local authority has been inaccessible throughout lockdown which highlights exclusion of those who are elderly, in deprivation or unable to use the internet for another reason. **BAME**: Darlington has a large BAME population with a large proportion of the Bangladeshi community or refugees unable to speak English as their first language. During the pandemic local councillors and healthcare professionals have regularly raised concerns that not enough information is accessible via the NHS or within the community in other languages about coronavirus or the pandemic. Healthwatch Darlington has included information links to 'Doctor of the World' in newsletters and media platforms. For many BAME cultural barriers already mean that communities might not engage with local services so any	None offered.

			information that might be available will be missed. IT illiteracy is also high in older BAME populations, potentially leaving them less likely to use the internet to access information, which makes them particularly hard to reach.	
Mental Health North East Region Wide	Poor access to care: mental health	Creative/diary-based work with children and young people (aged 3-21) Monthly Bulletin	Young people reported: • They missed family and friends that they couldn't see during lockdown. They also missed school/teachers, weekend routines and having other children to play with • It is hard to stay 2m apart and not hug friends and family • Missing birthdays and other family/social events • That there are also positives to reflect upon (i.e. new skills and opportunities, eating new foods, waking up later, spending more time with parents, spending more time in the garden). • Suggestions to help each other included: rewards for washing hands, writing letters/pictures to people who feel lonely, making lists of good things if you feel sad. • They'd like to have been spoken to by the government directly. • That working in close proximity at home was stressful at times. Exemplar Quotes: • "It has created new opportunities for me to learn new skills such as drawing, baking, playing guitar and lots more. I have spent time running and biking with my Stepdad and have a sports watch to see how far and fast I can go. We draw rainbows and clap every Thursday evening to show our support to the NHS and key workers such as my Nanna." • "It has been hard because I have not been able to see my friends every day as I normally do. It has been a weird experience to see people wearing masks and odd to see so few cars." • "Hindsight is a grand thing but based on information from abroad I would definitely have locked down the UK at least a fortnight before the actual lockdown. I would have worked with other countries to quickly introduce test and trace and a huge priority would have been to provide quality protection clothing and masks for NHS staff, carers and other worker who are constantly in touch with members of the public. In addition I would have personally attended all COVID meetings if well enough to do so. One last thing I would have followed the lead of Jacinda Ardern, New Zealand's Prime Minister and	None offered

			spoken directly to British young people and children explaining the current situation and what was being done to protect them and their families." • "Since my school shut down, me, my Mam and my Stepmam have been working from home on the dining room. table. We have also been getting stressed and we've been struggling with our work."	
North East & Cumbria Learning Disability Network and Inclusion North Region Wide	Poor access to care: learning disabilities	Keeping People Connected Project: co-designed Mid-March and delivered by 12 voluntary & community sector organisations across Cumbria and the North East. 13 localities took part in the project. Each locality was covered by 1 or more community voluntary sector organisation. Some organisations covered more than 1 area. Weekly data was collected from each area using an iterative template. 16-week Evaluation Report with case studies (14th April to 4th August 2020)	Project aimed to help people with a learning disability or autism to: Understand information from the Government Connect with others to avoid isolation Get the support needed for other things in their lives Consisted of: telephone/text/email support; activity packs; support services (such as prescription collection); online social networking. During the 16 weeks the project ran for, 1599 individuals engaged with the project, individuals were contacted a total of 22,213 times. The average cost per person for this support over the 16 weeks was £180.74. Some had a lot of support; others only needed a little. Much of this support was around: • Anxiety • Loneliness/isolation • Mental Health concerns The themes discussed on most occasions were anxiety (116), followed by loneliness and isolation (109) and mental health concerns (108). A number of additional themes were identified including: boredom, technology and support to use/access to, staying safe online, understanding official guidance, lack of routine and uncertainty about the future, suicidal thoughts and self-harm, frustration/anger, PPE/face masks, importance of pets, local lockdowns, public transport, relationship problems, possible eviction. Exemplar Quotes: "I look forward to my weekly calls because they make me feel less lonely" "I used to have a really regular routine, but it's all changed. I went to bed at 7 this morning and only woke up when you rang. I've been self-isolating for 2 months now and it's having a huge effect on me. I feel that my moods are up and down and the medication that the GP prescribed is not working for me. They keep upping it but the way I'm feeling, it's not doing anything. He is going to	The project has identified the need for Health and Social care systems to: • Better understand the needs of people on the edge of their services • To build community-based Voluntary Community Sector (VCS) relationships with the system and commit to working in partnership to deliver effective, quickly mobilised, community focused support to people when they need it. • Work out how we enable people to identify if they need support, not based on diagnosis or health classification, and give people the community support they need, when they identify need. • Work with people around the issues of loneliness, and distress well before they need a medical interaction from services, helping people build connections, and resilience.

			contact the Crisis team for advice about what he can do to help me sleep and have medication that doesn't mess with my moods. When I'm not good, I struggle to deal with upsetting and emotional things like my Mums cancer. I had a bath just to feel normal again. I love baths. I try and watch something boring on Netflix to help me drop off to sleep. I dropped off watching Call the Midwife, so I'll try that again." "Finally, some support. I feel like me and my son have been left high and dry and I'm grateful. We are struggling for food and my son is struggling with his mental health. We didn't know who to turn to, so you phoned at just the right time." "I'm worried about the long weekend –I'll hardly see anyone. It is like I don't exist." "Why does everything have to be online? That's one of the problems with this. If you can't read and write it's hard enough but then everything uses technology and you can't use that either. I like just to have you tell me what's going on. I don't understand what's on the telly in the news either". "Keeping People Connected has helped me throughout the lockdown as I was struggling due to the uncertainty and the strict curbs imposed on my daily living. Just having someone professional like Carolyn to communicate with really helped me and as a result I'm now feeling more upbeat alongside the lockdown being eased so I am able to return to the things that I like doing too. The service also got me interested in other services and clubs that Skills For People will run such as the All Autistics Accepted and the men's group which I look forward to joining when the venues are Covid-secure and back up and running. Many thanks again to Carolyn and the team."	
Ageing Better Middlesbrough	Older People	Case Studies (not dated). Provided digital devices to older people motivated to use the Internet but unable to afford a device. 2 older people, 2 digital support volunteers, 2 Digital inclusion officers.	Older people found the devices improved their ability to interact socially during lockdown.	None offered.

		Quotes from stakeholders reported		
Ageing Better Middlesbrough	Older People	Notes (compiled May 2020) - discussion with front-line staff about coping during pandemic. No information about sample.	Staff felt they had adapted well, continued to work well and productively as a 'remote' team, had the opportunity to develop new skills and reach new clients and confirmed the importance of Ageing Better's goal of addressing loneliness. They felt that valuable connections could also be developed remotely. Also reported frustration at plans put on hold and uncertainty about the future.	None offered.
Ageing Better Middlesbrough	Older People	Report compiled June 2020 – reports rapid development of a telephone befriending service to replace face-to-face support for older people. Captures learning from staff experiences of initiating the service. Sample - Ageing Better staff	Support needs changed over time from emergency help followed by practical day-to-day help then to finding activities to stave off boredom. Mental health: Clients were experiencing anxiety, frustration and loneliness. Clients struggled to differentiate between therapy and befriending and appreciate the limitations of befriending. Regular calls allowed rapport and trust to develop. Men were particularly responsive to telephone befriending.	Telephone befriending was generally reported as successful and should be continued particularly for those with mobility and mental health needs.
Durham County Carers' Support County Durham	Unpaid carers/risk of indirect harm	Online survey of carers to identify how to best support. 21 responses gathered during virtual carers' groups and during phone calls with support workers Report (July 2020)	Caring for people with learning disabilities, mental and physical health problems and older people. Reduction in formal services resulted in need to provide additional care. Contact, including online activities, from care providers has been appreciated. Lockdown has had a detrimental effect on carers' health, wellbeing and finances. Most carers would welcome resumption of services although some would be wary of their cared for person attending services. Some carers unable to access online support.	Durham County Carers' Support are seeking to provide carers with tablet devices and virtual training.
Durham County Carers' Support County Durham	Unpaid carers/risk of indirect harm	Report compiled August 2020 - trained volunteers contacting most vulnerable carers. 138 carers aged over 65 caring for person with learning disability,	Widespread loneliness. Distress caused by inability to visit loved ones in care homes. Lack of formal support and little contact from usual agencies. Financial difficulties. Interdependency an issue: carers needing care themselves. Lack information on entitlements and support.	None provided.

		dementia or mental health problem.		
Keeping People Connected, Darlington Association on Disability County Durham	Poor access to care: learning disabilities	Virtual support service offered via telephone or Internet. Case studies of 3 people supported. Not dated.	Lockdown causing distress and confusion over need to shield. Mental health was very poor. Clients welcome and benefit from contact. Potentially very serious harm was prevented by the service.	None provided.
Changing Lives and Centre for Public Impact Region Wide	Covers all 4 vulnerable groups: Homeless, D&A, Low income families, Domestic abuse, Sexual exploitation, Criminal justice	Structured conversations initiated by Changing Lives staff or Fulfilling Lives EbE Network members with people they had existing relationships with. Followed up with two sense-making virtual focus groups where the data were analysed. 90 conversations, 2 sense-making virtual focus groups Report – not dated.	Withdrawal of formal services resulted in loneliness and isolation, particularly among BAME people. Online support welcome but not a substitute for face-to-face contact. Positive experiences of increase autonomy among those with addictions freed from regular appointments. Lack of attention being paid to mental health and health anxiety due to official focus on physical health.	Listening exercise being expanded to an extra 150 people. Plan to develop a toolkit for inclusive listening; share voices with decision makers; host a webinar to shape services and systems.
Changing Lives Region Wide	Covers all 4 vulnerable groups: Homeless, D&A, Low income families, Domestic abuse, Sexual exploitation, Criminal justice	Briefing – not dated. Outlines impact of changes in prescribing due to COVID for people accessing York Drug and Alcohol Service (YDAS) and in receipt of opioid substitution treatment (OST). Reports results from a survey of 73 people who had moved from supervised to unsupervised OST between May 31 and July	Pre-COVID 64% of people on OST were required to attend pharmacies for supervised consumption. During pandemic this dropped to 2%. 97% of respondents reported that the move to unsupervised OST was overwhelmingly positive in terms of managing time, managing their prescription and reduced stigma. Half of respondents reported reducing their additional drug use. Most interestingly, across the YDAS there was a 63% reduction in reported incidents during lockdown compared to the same period in 2019. Most significant reductions were in overdose (75% reduction), deaths (57% reduction) and prescribing errors (100% reduction).	Results are indicative that a return to supervised OST would result in a loss of progress and trust. Recommends a review of supervised prescribing to identify people who could move to unsupervised OST; working with other providers to broaden the evidence base; work with York Public Health to address wider community impact and unintended consequences.

		2015. No detail on how survey was administered.		
VCS Assembly Northumberland	General	Survey of 74 VCSE organisations in North East to gain an understanding of the impact of COVID-19 on the VCSE. Report of survey results	70% reported that service users had been affected to a great extent by COVID. 81% had ceased some projects. 59 % had moved projects to online/telephone only. 51% felt they could play a role in the crisis. 71% had reported a decrease in total income. 54% had reserves of six months or less.	Most major challenge was loss of income and resuming projects after the crisis. The most pressing demand was for funding advice.
VCS Assembly Northumberland	General	Brief survey undertaken in early April 2020. No information on how many organisations were surveyed. Report (not dated).	Results indicated significant income loss between April and June in a period when fundraising would normally take place. Half of respondents had only six months' reserves indicating financial distress. Reasonable levels of uncertainty over whether they could continue to operate. Over 40% had been unable to operate their services at all with a significant impact on beneficiaries. Loss of staff would have an on-going impact on their ability to respond to need and a probably increase in demand. VCSE will need to rethink how they operate with fewer resources.	Small organisations will face the biggest impact. A financial stability fund in the region of £4 billion will be needed to support the VCSE sector. Additional funding should not be restricted to charities dealing specifically with COVID-19.
VCS Assembly Northumberland	General	Case Studies - no information on how data were collected. Overview report of VCSE response to COVID-19 response in Northumberland.	Identifies emerging issues: COVID-19 support groups indicated desire to continue post-COVID. COVID volunteers need to be retained post-COVID. Not all support can be offered to all groups remotely (some require face-to-face). Funding is a major issue due to lost fundraising opportunities and focus of funders on COVID response to detriment of other issues. Demand for mental health and debt advice has increased the most. Crisis has further highlighted inequalities, including in digital exclusion.	The sector will require significant financial support. The VCSE must be involved in COVID recovery planning to address inequalities. VCSE should be involved in future crisis planning.
Connected Voice Newcastle	BAME groups	Notes from issues raised at network meeting June 2020 Reports on issues presented by BAME community members but no details provided.	Mental health a key issue of concern for BAME communities due to Covid-19, lack of appropriate mental health services for this community. Existing inequalities have been amplified. Particular concerns for asylum seekers - isolation, poor accommodation and overcrowding, lack of money, social networks, and fear of being arrested if leave the house. EU citizens are particularly vulnerable - access to universal credit is an issue and needing to apply for settled status. Concerns over safeguarding children who are not in school. BAME young people experiencing - hate abuse online, crowded households, no outlet for pressures, scared parents may be affected working in care professions. Everything online not a solution - digital exclusion, people having no access to internet, computer or phones. Lack of clarity from Govt - covid health messages too complex and not in plain English. BAME people are	Network asks for the following in light of discussions at meeting: what is the future plan, how do we build recovery for organisations and for communities? Need clearer messages in future and for these to be cascaded to frontline workers who have been at the forefront of explaining them to those they work with. Need to learn from what has happened, what do we do differently, how do we deal with second waves? Need role models through all our work

			experiencing hate crime/discrimination - being targeted due to news that BAME people are more at risk.	and city to provide proper equality and access to opportunity for all. Better BAME representation in health settings and organisations.
Healthwatch Sunderland	Clinical complexity: Shielding; Increased risk of transmission: High risk behaviours (smoking, drinking)	Online survey (paper versions available) on people's experiences of using health and social care services during Covid-19 from June 2020. 714 members of the public. 403 female, 153 male, 1 non-binary, 3 preferred not to say, 154 skipped question on gender. Age range 13-75+ greatest representation in 45-64 age category. Sample heavily skewed to female, white British population Report of survey findings.	Overall, people's experiences of using services during the pandemic has been a positive one, especially those people who have used healthcare services. **Information and advice**: Whilst the majority of respondents found it easy to find (86%), understand (81%), act on (78%) and keep up to date (77%) with COVID-19 related information and advice, there were clear themes around those areas where more support or clarity would have been useful, such as access to GPs, dentists, prescriptions and the management of existing conditions. **Healthcare support**: The majority of respondents who used healthcare services rated them as good or excellent (82%), but almost one in five rated their experience as 'fair' to 'very poor'. The feedback highlights communication could have been better to help alleviate uncertainty during this challenging period. **Social Care support**: Communication of changes to social care support highlighted more of an even split between those rating their experience as 'good' or 'excellent' (52%) and the remainder who rated their experience as 'fair' to 'very poor'. Again specific feedback highlighted communication of changes being critical. **Mental Health and Wellbeing:** 53% of respondents stated their mental health has been negatively impacted to some extent during the pandemic. Of those who responded, 41% had decreased levels of exercise, 36% were smoking more, 22% were drinking more alcohol and 41% had gained weight. These figures are a cause for concern and are being shared with Public Health to support them in their planning for supporting the residents of Sunderland localities to keep well.	Next steps to share this information with providers and commissioners to provide robust information upon which to build future service responses.
Tyneside Women's Health Newcastle	Poor access to care: Mental Health	Individual, mainly open text, responses to ten questions. Raw Data No information on sample provided.	Unable to provide summary - 86 pages of raw qualitative data that require primary analysis.	Unable to provide summary - 86 pages of raw qualitative data that require primary analysis.

Bliss=Ability South Tyneside	Poor access to care: learning disabilities	6 Case studies from individuals referred to Bliss programme via social workers/link workers or self-referred; 3 dated (August 2019, Feb 2020, August 2020) Unclear sample, all appear socially isolated resulting from physical or mental illness. No demographics.	Positive outcomes in each case study - requires primary analysis to draw case study findings together.	None offered, individual case studies - requires primary analysis to draw conclusions.
Durham Community Action County Durham	General	Survey data from VONNE and three summaries from meetings in July and August. Focuses on the impact on Voluntary and Charity organisations not members of the population these orgs provide services to. No demographics reported.	VCSE Support needs based on VONNE survey results and consultations with community organisations: funding advice, new income streams, and strategic planning and financial management.	None offered.
Healthwatch South Tees	Clinical complexity: Shielding; Increased risk of transmission: High risk behaviours (smoking, drinking)	Online survey; findings supported by the qualitative study 'The Dr Will Zoom You Now' where Traverse, National Voices and Healthwatch England spoke to 49 people about their experience of remote consultations. Demographics: 380 respondents (84% female; 95% white British)	**Positive experiences of services during lockdown:** • 46 people mentioned specific services, staff and teams. People appreciated the communication and support offered by staff, both in face-to-face settings and over the phone ('*knowing we had somewhere to call and someone checking in made all the difference*'). • 43 respondents had positive experiences of health and social care during lockdown, due to the efficiency of services. This mostly related to GP surgeries and pharmacies, which were often described as "quick" in comparison to pre-COVID-19 experiences of waiting times and communications ('*able to get appointment and seen same day*'). • 134 people stated there was nothing more services needed to do to improve. **Negative experiences of services during lockdown:** • 27 people expressed difficulties with keeping appointments that had already been booked, due to cancellations within GPs and hospitals but also within	Underrepresentation of characteristics such as males, BAME backgrounds, younger and older people, and those with disabilities. Report outlines plans to build on this work through Community Champions scheme, where Healthwatch South Tees hope to make contact with people from different backgrounds and gather their experiences of lockdown, then make comparisons to these initial findings. **HWST recommendations:** • Ensure social distancing measures are in place and followed by everyone at

		Age breakdown: 23% - under 34 65% - 35 to 64 11% - over 65 19% stated they had a disability; 11% had been advised to 'shield' during lockdown; 6% believed that they have had covid at some point during lockdown. Collected between June and August. Recognises limitations of sample: 'response demographic was mostly middle-aged, white women, and so our findings are not representative of the diverse population of South Tees'.	social services. Difficulties also experienced when trying to get the correct medication and aftercare, from services including pharmacies, hospitals, and dentists ('*missed important operations supposed to have every three months and waited 10 months*'). • 13 people felt that felt better communication between services and the patients was needed both during and after care, including information about appointment times and treatment procedures. This was most commonly about the 111 service and hospitals and was especially relevant if people had been promised a phone call, but this had not been fulfilled. Another popular response was that people would like to have received regular updates about service guidelines, e.g. who is allowed in the GP surgery and whether face masks are needed. • A lot of people felt that their own care, for health issues unrelated to COVID-19, had been negatively affected by the changes that both primary and secondary care services had quickly made. For example, in relation to maternity services, Many women detailed how communication during pregnancy and in their post-natal care had been very limited and there was also the suggestion that their basic care needs had been ignored. Based on their experiences of being alone at critical points of their maternity care journey, some women strongly suggested that fathers and advocates needed to be allowed access ('*spent 4 hours alone'*). **Face to face Appointments:** • 36 people appreciated how organised services were in safely adapting to COVID-19 and communicating these changes to patients. This preparation made people feel more at ease when turning up to services. People were less concerned about infection when they could see staff wearing full PPE. • In contrast, 16 people felt that more adjustments and practical changes were needed to make the process of attending face-to-face appointments easier and safer in the current climate, e.g. more social distancing in hospital waiting rooms, and less waiting around in busy corridors. Some people wanted to see more staff wearing PPE and face coverings. **Phone and Video Calls:** • Positives: A total of 19 people reflected how video calls were beneficial for the current climate; patients can access care in the safety of their own home, without coming into contact with others and therefore helping to prevent the	the service, with reminders of guidelines clearly visible on the site, particularly in waiting areas. • Send guidelines to patients before appointments via. text messages / emails, so that they feel comfortable and informed when attending and navigating services. • Keep websites, leaflets and text messaging systems up to date with information about service changes and how to access services and receive care, safely. • If appointments have to be cancelled, or service provisions have been pulled, ensure patients understand the reasons for these changes, let them know of alternatives for their care, and keep them up to date with any reorganisation. • Because COVID-19 and lockdown have affected mental health, it will be important to ask about all aspects of wellbeing in future appointments to achieve a holistic approach. • Think creatively about how alternative support can be given by adapting service delivery. **HWST top tips for virtual appointments (professionals):** • Give patients a precise time window for their appointment alongside guidance of what to expect; patients won't have to wait and can ensure they will be in a confidential and safe place. • Offer and communicate the opportunity for patients to send

			spread of infection. Some stated more efficient than face-to-face appointments, saving time in both waiting and travelling *('could see two specialists at the same time').* • Negatives: Some people had experiences of waiting for appointments due to not being given a clear time window. Many patients felt rushed during phone and online consultations and would have preferred more time to talk, ask questions, and express concerns. This was a notable when the video-call was with a new GP, meaning more time would have been preferable to build trust. For some, physical examinations would have been more appropriate as video consultations were not always practical, e.g. for blood tests and blood pressure readings, as well as for physical symptoms and signs. In the same way, video calls were not always suitable for some patients' needs and accessibility, especially for children and those with anxiety or hearing difficulties. • In addition, connection issues affected the quality of the video, meaning patients and health professionals could not hear or see each other. Patients suggested that sending images prior to appointments would be beneficial in eliminating the impact of connection difficulties and ensuring care could still be given. • For some, the main problem with video consultations was trying to access their appointment, with devices blocking permissions or not having a microphone and webcam. Alternatives should be explored for those who may be digitally excluded, or for those who may not want to discuss private medical issues in public spaces. In these instances, a lot of people had to change to phone consultations instead. **Mental Health:** • The majority of respondents have had 'ups and downs' with elements of worry, but then becoming more settled as time passed in lockdown • People noted negative experiences of feeling stressed, worried and depressed throughout lockdown. For a lot of people who already had anxiety, these feelings were made worse by the uncertainty of lockdown, causing some people to experience panic attacks. Some people's mental health had been affected by the death of a family member. • Lockdown had a negative impact on support systems, reducing contact with family members and with external services, making people feel lonely. The experience of lockdown, specifically for those with young children, made	photos of physical symptoms e.g. rash, prior to consultation so that the health professional can have an understanding of the health issue before the appointment and give answers within the time slot. • To reduce the impact of digital exclusion and/or illiteracy, ask patients about their confidence using technology, and advertise alternatives to video consultations on the website, at the surgery, in appointments and via text messages. • To maximise the time window for appointments, ensure the necessary preparations have been carried out prior to appointments, e.g. read patients' medical notes so they don't have to repeat their story. • To ensure the patient gets the most out of the appointment, check they can clearly see the video, and hear what is being said at the beginning of and throughout the appointment, and use the chat function if difficulties persist. • Try not to make the patient feel rushed throughout the consultation, so that no information is missed. • To achieve a holistic approach to wellbeing and care, ask about aspects of the patients' mental health in the appointment. • To ensure patients understand their care journey, explain what is happening next and who is responsible for the next stages of care, e.g. where

			people feel exhausted having to balance their working and home life without any external help, e.g. childcare, grandparents and school. • The feeling of loneliness was a particular issue for those labelled as 'key workers' and those who had been 'shielding'. • For a smaller proportion, people had felt relatively 'happy', either not being affected by the imposed changes, or lockdown helping with existing anxieties ('gave me the space, helped me get over my anxieties').	to access medication or when to expect a follow up. • Seek feedback about people's experiences of virtual consultations and use this to improve the service **HWST top tips for virtual appointments (patients)**: • To feel involved in decisions about your care, ask for a precise time slot of when to expect your remote consultation, and let the service know how you would prefer to communicate, either by phone or video. • To ensure you are comfortable in your appointment, and there is knowledge of your medical history, ask if you can talk to a GP who you may have already built a rapport with. • To get the most out of your appointment, prepare what you want to discuss, check the quality of your connection in the area that you want to have your video consultation and have a test run. • Make notes throughout your appointment and ask if you can have another appointment if you feel you haven't had enough time to discuss your issue, or for a face-to-face appointment if you believe this is more suitable. • If you're unclear on what happens next, ask your healthcare provider to summarise the next steps.