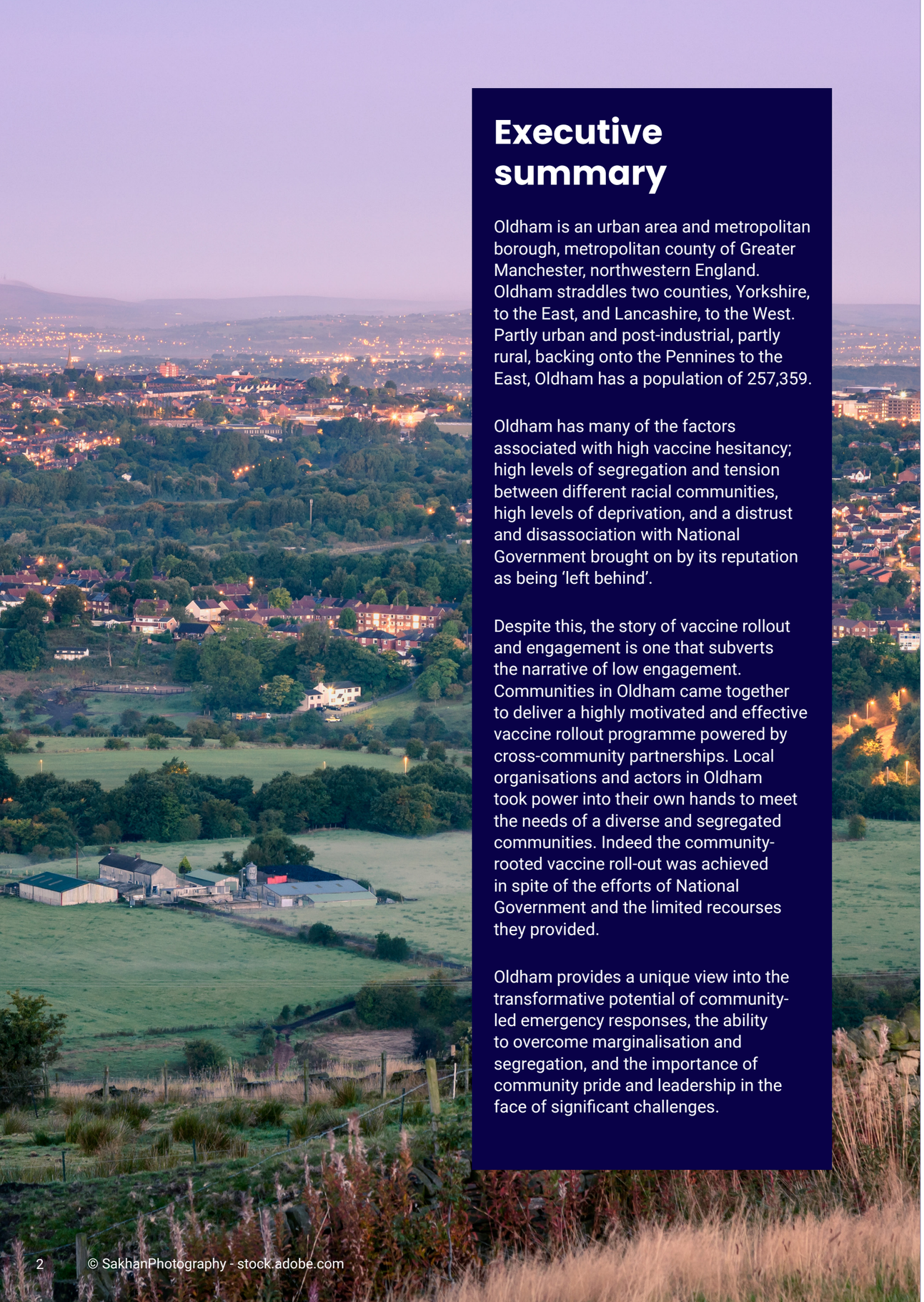
Institute for Community Studies

Powered by The Young Foundation

Case study: Oldham, UK

Research conducted by
Institute for Community Studies (ICS) UK



Executive summary

Oldham is an urban area and metropolitan borough, metropolitan county of Greater Manchester, northwestern England. Oldham straddles two counties, Yorkshire, to the East, and Lancashire, to the West. Partly urban and post-industrial, partly rural, backing onto the Pennines to the East, Oldham has a population of 257,359.

Oldham has many of the factors associated with high vaccine hesitancy; high levels of segregation and tension between different racial communities, high levels of deprivation, and a distrust and disassociation with National Government brought on by its reputation as being 'left behind'.

Despite this, the story of vaccine rollout and engagement is one that subverts the narrative of low engagement. Communities in Oldham came together to deliver a highly motivated and effective vaccine rollout programme powered by cross-community partnerships. Local organisations and actors in Oldham took power into their own hands to meet the needs of a diverse and segregated communities. Indeed the community-rooted vaccine roll-out was achieved in spite of the efforts of National Government and the limited recourses they provided.

Oldham provides a unique view into the transformative potential of community-led emergency responses, the ability to overcome marginalisation and segregation, and the importance of community pride and leadership in the face of significant challenges.

Demographic profile

Ethnicity	20% of Oldham's population is from ethnic minority backgrounds. • The majority of ethnic minority residents in Oldham are South Asian (10.1% Pakistani, 7.3% Bangladeshi, 0.7% Indian) • A small minority are Black (1.2%), Mixed (1.8%) or other ethnic groups (1.4%) (1). • Between 2001 and 2011, the proportion of the population from white backgrounds decreased from 86.2% to 77.5% (1), whilst the South Asian population continued to grow. Residents of Pakistani heritage increased from 6.3% to 10.1%, and those of Bangladeshi heritage increasing from 4.5% to 7.3%. These communities primarily live in the wards surrounding the town centre - typically the most deprived areas in Oldham.
Age	• Oldham's population is relatively youthful. 22.6% are under 16, compared to the national average of 19.1%. 15.8% are over 65, compared to the national average of 17.9%. • Oldham's age structure has also changed in a different pattern to England's overall ageing population. The population of over 65s in Oldham has increased since 2001, but the proportion of under 16s has remained approximately the same because of the growth of South Asian communities which tend to be of a younger demographic (2).
Income and Wealth	• Oldham is one of the 20% most deprived districts/unitary authorities in England and about 29% (15,000) of children live in low-income families (3). The average household income is £22,858.

History: marginalisation and resistance

Post-industrialisation

Oldham has encountered a number of shifts and changes that have characterised its demography, economic profile, and community cohesion. Oldham's economy has historically been built on manufacturing, specifically textiles and mechanical engineering. Structural changes across the UK's economy have meant that Oldham has experienced significant economic restructuring, and ensuing unemployment and deprivation. By the 21st century, the local economy was driven primarily by advanced manufacturing, construction, and service industries (including health, digital and financial services). Although the number of small and medium sized businesses have been increasing over the last decade, public sector employment plays a major role in Oldham, with over a fifth of all employment being in the public sector. 9.3% of this is in the NHS, leading to a total of 32.8% of Oldham's population being key workers (2, 4). The large number of key workers in Oldham's economy has been one factor observed to exacerbate the impact of COVID-19 on Oldham's population.

The last two decades have replaced a narrative of post-industrial decline and deprivation with a narrative of segregated and non-cohesive communities. The term 'left behind' which has problematic connotations, has been frequently used to describe Oldham's current socio-economic status (4). This narrative has heightened significance in Oldham, given the BNP's stirring of friction over racial segregation in the late 90s and early 2000s (5), and the continually reported incidences of conflicted race relations.

Oldham is consistently regarded in the media and published studies as an area with high levels of deprivation. Oldham has been identified as the most deprived place in England: possessing the highest proportion of deprived areas in the UK and the second lowest house prices behind Burnley (5). Oldham also hosts some of the most pronounced disparities in inequalities when comparing 'White' and 'non-White' populations across a range of indicators (6). The frequent portrayal of Oldham as a deprived area has had a damaging and stigmatising effect on how residents and local actors perceive their community and furthermore, its ability to change (5).

The Oldham riots

Oldham had an unwanted reputation as a disaster area embroiled in social turmoil, economic and infrastructural degradation (7). One of the most destructive episodes of social turmoil were the 2001 Oldham riots. These riots took place over a three-day period throughout the borough and were highly violent, including the use of petrol bombs, bricks, and bottles, with over 20 people being injured. The trouble spilled over and there was violence in Bradford, Leeds, Burnley, and Stoke. But the most widespread problems remained in Oldham.

The riots were not a spontaneous phenomenon, but were rather a culmination of several long-, medium- and short-term factors. The backdrop to these riots was mounting racial tension between South Asians and White residents. From a long-term perspective, significant numbers of South Asian migrants arrived to fill the gap in domestic employees; they settled in more deprived parts of Oldham and were often subject to racist abuse. This prompted an inward perspective for South Asians, who deepened their existing intra-racial familial relations (8) propagating a view that communities of different ethnicities were living 'parallel' lives to each other (9).

At this juncture, we can introduce an important alternative perspective on the source of this so-called segregation. The textiles industry provided a common meeting ground for various ethnicities; economic restructuring meant that this common thread was broken, and each community turned inwards (10). As Rhodes et al (5) puts it; 'we had that sense of community and I don't think we lost the sense of community because we had immigrants. I think we lost the sense of community because we lost the industry.

The Oldham riots were seen as the culmination of clashing identity politics fueled by deep seated and decades long deprived conditions, including high unemployment, for communities in Oldham. A degree of delicacy is needed when discussing the Oldham riots, because the riots are still used as a tool to flare tensions and have cast a shadow over Oldham's reputation. Provoked by an intervention from a small number of groups in an area of depressed social conditions, the unrest developed into violent clases between mainly South Asian youth and the police. The riots were seen as a failure both of community cohesion and social policy, with reports citing 'self-segregation as a contributory factor' (11).

The problem of cohesion and race relations in Oldham has been assessed in reports over the last 10 years as a still present concern. Indeed, the concept of community cohesion was conceived in response to the 'race' riots in Bradford, Burnley, and Oldham (12). However, reports on this topic highlight worries that the resource stripped from local governments to support cohesion programmes had resulted in limited change to the segregation of different communities in the borough. Prof Ted Cantle said the likes of the need to combat terrorism has "overwhelmed" community cohesion work. Oldham Council said a lot of work has been done to tackle the problem (13).

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Post-riots

Oldham has been seeking to reposition and recently, rebrand itself in last 15 years, to move beyond its experience as a 'riot town' (14). An example of such an effort is the Oldham Town Centre Partnership (2006), which was core to coordinating the work of a variety of stakeholders States its mission as: "To create the conditions for a major step change in the growth and competitiveness of Oldham Town Centre and to maximise its life, vitality and commercial viability as a sub-regional destination in Greater Manchester" (7).

Oldham's reputation for racial segregation and antagonism has proven hard to shake, evident in the fact that Oldham featured prominently in the polarising 2016 Casey Review into integration, specifically problematising the on the 'less progressive views' held by Muslims (15). The Casey Review also introduced extremism into the conversation around integration, creating another unwanted reputation for Oldham.

Distrust and disconnection

The trauma of the riots and broken social ties reverberates throughout the vaccine hesitancy seen in Oldham. The experience of South Asian communities in the riots can be viewed in conflict with White communities, as well as the police. The police were perceived as not wanting to do anything to support South Asian communities in the build up to the riots (16) and culminated in the police being physically attacked during the riots. The traumatic memory of this violent encounter with the police is likely to have created strong distrust of authority. Months later, the atrocities committed on 9/11 were to cast an additional layer of suspicion on Muslims, most of whom are South Asian. This creates a potent source of distrust and disconnect between Asians and authority, which was reflected in the account of the distrust.

This distrust may well be deeper and older than the riots. The employment structures that developed in Commonwealth Britain echoed a Colonial one. This was quite clear in Oldham, in which Asian labourers worked in textiles, which was and still is a major specialism of South Asia. In this sense, Asian workers still occupied the same division of labour which was used during the Colonial period (17). The distrust of authority that was expressed during the Colonial period thus finds some contemporary expression in the police, and the vaccine rollout.

Vaccine rollout is perhaps also harmed through a distrust of media that also developed before, during and after the riots. Mobile phones were used to spread rumors, the police used of video surveillance in riot-related court cases, and the local print/radio media all played new and important roles in riot-related events. These technologies were used to promote racially oriented views of events prior to, during, and after the riots (18). In the twenty years since the riots, mainstream media has also presented Muslims in a particularly negative light, entrenching this strained relationship. This would lead to a discontent with sources of information that could serve to correct misconceptions around vaccines.

Political ecology

Despite being a seemingly safe Labour seat, Oldham is shifting away from its Labour dominance, towards a more contested space. Local politics is still largely dominated by Labour with 40 out of 60 councilors being of the Labour Party, 11 being Conservative, and 8 Liberal Democrat. However, recently the Labour incumbent lost their seat to an independent party representative (19). The unseating of Sean Fielding, who was elected leader in May 2018, provoked questions over the importance of electoral boundaries (20). Mark Wilkinson, of the newly formed Failsworth Independent Party won Fielding's seat. This tension over changing electoral boundaries suggests that Wilkinson's victory has been disruptive to the existing political ecology.

This tension is reflected at a national level as well; although Oldham has been represented by Labour MPs since 1997, the Conservatives have slowly increased in the share of their vote over the 2010s. In the 2019 general election, Labour lost 11% of the vote, whilst the Conservatives gained 3.2%; Debbie Abrahams MP was narrowly re-elected with a margin of 3.2% over the Conservatives (21). The extent to which this shift represents changes in opinions and sentiments of residents is difficult to ascertain because Oldham has suffered from low electoral turnout with voters described as 'disenfranchised' from the democratic system (22).

This backdrop of marginalisation and deprivation has created a sense of exclusion especially in regard to the areas' relationship with the Greater Manchester authority. This authority has typically approached local and inclusive growth through a technocratic lens. In contrast, Oldham has adopted a localised approach to economic growth. In this sense, Oldham has incorporated a sense of marginalisation into its local development policy.

Oldham Council has also experienced a significant decrease in their budget under austerity; since 2020, the total budget cuts amount to £208 million, equating to around 60% of their total budget (23).

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Civil society

Oldham has at least 274 registered charities, and 1,231 organisations in the Voluntary Community and Social Enterprise sector. Charities engage with a multi-ethnic client group in order to build relationships though disparate and disconnected communities. The Ghazali Trust, for example, is a South Asian Muslim community effort to empower individuals and communities and remove barriers through the means of sports, education, arts, and community participation.

Approximately 37,000 people volunteer in Oldham, out of 237,410 which is around 15% of the population. Recent austerity cuts have reduced the budget for community groups' work on social cohesion by over 50% for some communities in the last ten years (5).

Healthcare situational analysis

Health inequalities

Oldham is among the top 20% most deprived boroughs in England. The health of people in Oldham is generally worse than the England average. Life expectancy for both men (72.7) and women (80.7) is lower than the England average of 79.5 for men and 83.10 for women.

Oldham has a number of long-term health inequalities. The proportion of people on GP registers in Oldham with a diagnosis of diabetes has been slowly increasing for the last 5 years. Data from 2016/17 revealed a prevalence of 8.1%, higher than national average of 6.7%, and the Northwest average of 7.1%.

The occurrence of severe mental illness (a diagnosis of schizophrenia, bipolar affective disorder, and other psychoses) in Oldham is higher than the national average (0.99% in Oldham compared to 0.92% nationally). The prevalence of people of all ages in Oldham with dementia is 0.8%, and with depression is 10.4% (24). In Oldham the main diseases contributing to premature mortality (deaths in people aged under 75) in 2011 for both males and females are cancer (40% and 46%) and cardiovascular disease (26% and 22% respectively).

Oldham also ranked poorly (3rd in 2011) in terms of ethnic disparities in health. 25.7% of the local Black and minority ethnic population compared to 20.4% of White British residents have a limiting long-term illness (25). Several long-term illnesses lead to a higher chance of death after contracting COVID-19 (26). The impact of this is that ethnic disparities in health outcomes are entrenched further.

Impact of COVID-19

Health

Infection rates in Oldham have been among the highest in the country. The mortality rate from COVID-19 in Oldham is 2.4 per 1000, leading to 743 deaths in total. This is the second highest in Greater Manchester, and the 4th highest across England. In most age ranges, more COVID-19 cases have been women than man. In terms of ethnicity, white populations have had the most COVID-19 cases (27).

Social services

The disproportionate impact of COVID-19 has also caused significant strain on social services, which have already been seriously impacted by austerity cuts. During lockdown, radicalisation, child sexual-exploitation and domestic violence have all increased considerably (28).

Vaccine rollout

Entrenched poverty, inequality, community division along racial lines, and a feeling of neglect from Government actors means that Oldham is an area with a high potential for vaccine hesitancy. However, the Council was successful at working closely with community leaders to address vaccine hesitancy among ethnic minorities; this has included making an online 'asset bank' including videos and promotional material, translated into other languages (29).

A key mechanism for distributing the vaccine has been through a series of pop-up clinics. Small vaccination clinics have been set up in mosques, community centres, and the Oldham Millennium Centre, which vaccinated more than 1,100 people in a single day. There was a number of strategic moves involved in the rollout of the vaccine: 30 Imams were vaccinated in one of the first vaccine clinics to encourage confidence among Muslims; COVID-19 'helpline' set up with trained volunteers from different communities to take calls from those wanting to discuss the vaccine and make outbound calls to different low uptake groups. The overall impression that emerges of Oldham's vaccine drive is an intensely localised one, driven through effective collaboration between the Council and community groups.

These efforts have been fruitful, with the Royal Oldham Hospital recently celebrating administering its 50,000th vaccination 390). In May 2021 when this study started, the % of first dose was 29%, and the % of second dose 27%. A rapid increase then occurred: by July 2021, 110,027 of Oldham's 200,779 residents (54.8%) have received at least one dose of the COVID-19 vaccine, slightly less than the English rate of 55.74%. Oldham ranks 24 out of 36 for All English metropolitan boroughs for first dose vaccination rate.

Workshop findings

The research team explored several questions in the workshops:

1. **What have been your experiences of delivering the vaccine programme and encouraging vaccine uptake?**
2. **What challenges have you experienced?**
3. **How would you describe the response to these challenges and the key initiatives you have used to address vaccine hesitancy with communities?**
4. **What initiatives, systems, or ways of working, have developed during the pandemic and how would you estimate the efficacy of these?**
5. **What are the future challenges that you are anticipating and what learning could you apply?**

The economic disparities and various social fault-lines made is clear early on that vaccine uptake would be a challenge. The slow initial uptake of the vaccine confirmed the extent of the challenge. Workshop participants detailed that a transformational shift then occurred, led by a faith leader who identified the gap in collaborative working between the local government and the healthcare system, communities of faith and cultural representation. A dual working group structure formed which brought together faith leaders and those working with other high hesitancy groups.

Local context

The workshops explored local community context that formed a backdrop to vaccine hesitancy. Established racial tensions were heightened when national data and news media showed that Pakistani and Bangladeshi communities had more cases of COVID-19.

The history of racial tensions had previously instigated a number of long-standing relationships that formed as a buffer against division. These relationships, such as between mosques and churches, were crucial in the vaccine uptake drive. Oldham also has small minority ethnic groups, particularly Black communities, which were often harder to reach, especially when compared to the larger ethnic minority groups.

Oldham's poverty rate has been a huge driver of vaccine resistance and hesitancy in local communities, of different ethnicities and age groups. One participant recalled an anecdote where they were doing door-to-door vaccine conversations: an Oldham resident remarked that he has bigger problems than COVID-19 as he was living hand to mouth, with two young children and poor accommodation.

Vaccine hesitancy

There are a number of reasons behind vaccine hesitancy that emerged from the workshops:

- **Distrust of authorities and health system**
  Participants reported distrust of the Government, their motives, and the ingredients of the vaccine.
- **Poverty**
  Many Oldham residents face severe deprivation leading them to believe that the 'vaccine is not my top priority'. Furthermore, a sense of alienation and being disenfranchised was connected to poverty. There was a sense that the residents would be swiftly forgotten again after the vaccine had been administered.
- **Ethnicity**
  Workshops explored concerns of racism around vaccine rollout intersecting with poverty and simmering racial tensions. Pakistani and Bangladeshi communities had a higher incidence of COVID-19 than other communities in Oldham meaning that vaccine rollout focused on Pakistani and Bangladeshi communities. Vaccine data by ethnicity was nationally released without any notification to community groups or leaders and contributed to a narrative that certain communities were being prioritised above others resulting in flare ups of racial tension. Organisations who sought to bring about better community cohesion needed to be clear to local communities about how vaccines were distributed and system of 'need and prioritisation' was seen to be in place by the local residents.
- **Faith based communities**
  Workshop participants noted that there is an overlap between Oldham's considerable Pakistani and Bangladeshi communities and being Muslim. Initially, there was considerable hesitancy among some Muslim communities towards receiving a vaccine partly due to concerns of vaccines being made with animal products. This elicited a response from local Imams who led the Muslim communities by being vaccinated first.
- **Smaller minority communities**
  Oldham has groups of smaller minority communities, notably the Black community, who reporting feeling disenfranchised, and were less easy to reach, as vaccine rollout efforts tended to focus on the larger Pakistani and Bangladeshi communities.

Vaccine rollout

The system that emerged to coordinate the vaccine roll-out and consecutively, combat vaccine hesitancy, was led by two principal actors working together. Firstly, the 'Vaccine Working Group', which was comprised of GPs, social care, primary care and community health representatives, alongside local government, and frontline social organisations. Secondly, the 'Equalities Group', which was comprised of representatives from different faith organisations, different charities, networks representing people with disabilities, community groups and those representing vulnerable communities.

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Working together, these two groups facilitated a number of pop-up vaccination clinics. Workshop participants warmly mentioned the vaccination clinic at the Millennium Centre as being particularly effective, vaccinating over 1,000 people in a day. This dual-agency system was developed in reaction, and in spite of, the directives of the national system.

The national directive from Public Health England for the vaccine rollout was described as sudden and was offered with limited support to local authorities and health systems. Public sector leaders in Oldham case described having 24 hours' notice for vaccine rollout. They were provided only with the vaccination doses, gloves, limited PPE and limited advice and guidance. They were not, according to consensus in the group, told how many vaccine doses would be distributed to the area. Despite this unfavourable circumstance, workshop participants said that they were still able to 'make the best of it'. Key to the success of the rollout, as reiterated by another participant, was the willingness of local parties and community groups to work together.

"the (national) system forced us to behave and act in a certain way"

The engagement approach taken by agencies in Oldham was to focus on the experience of the 'whole citizen' and join together various systems and organisations. It was necessary to navigate layers of bureaucracy around systems of eligibility, booking, coordinating uptake, and communicating information about the vaccine. The workshop participants noted that smooth co-ordination of these various elements could be achieved by simply 'picking up the phone and ringing people'.

One particular challenge that was frequently discussed in the workshop was the lack of locally specific and integrated data. The lack of this information meant that agencies in Oldham did not have an up-to-date or 'usable' picture of which communities were most at risk, where take up was highest, fastest, or challenging, what cross-institution staffing, and systems were available to resource the vaccine centres on a daily basis. They lacked a profile of where the hardest to engage communities were and what barriers they were facing to vaccine engagement.

Oldham's response to this was to build their own data infrastructure to suit the needs of the borough. This system was designed to manage, monitor, deliver, and adapt to the challenges of the vaccine roll-out. The data system and architecture were built from scratch and was bespoke to the requirements of particular challenges in Oldham. Workshop participants reflected that the creation of a new data system took a radical approach to integrating existing data sources and plugging gaps where data did not exist. There was a particular need to draw on tacit and local knowledge and the role of Community Nurses and Volunteers, going door to door, was considered essential to meeting this need.

"That street - I can tell you every household in that street and exactly how many of them have, or haven't had the vaccine. What I can't tell you conclusively - is why".

One workshop participant discussed the formation of local, grounded groups that enabled the collection and circulation of local information. A faith leader, in one workshop, reported noticing the gaps in communications between various groups and began connecting them. This resulted in the creation of a fluid, reflexive network of community groups.

When participants were asked about which areas of the vaccine rollout could have been improved, they acknowledged that having a single clinical lead actor would have useful, as well as a better engagement with pharmacists.

Community response

Amongst residents in Oldham, there was significant criticisms about National Government and Public Health England both in the handling of the pandemic and the rollout of vaccines. As a response to this, workshop participants spoke of how they had to 'bring the system to the people', meaning they brought about structured vaccine rollout for people who needed them, with only an unpredictable provision of vaccines and PPE to support them.

Workshop participants regarded Oldham's structure of vaccine rollout as a hyper-localised model. Part of this model was a flat hierarchy with no power structures between members of the working groups, who were connected by a common interest in encouraging vaccine uptake. Discussions mentioned specific features that were seen to 'work' in engaging communities in vaccines. Specifically, an effective network of community nurses, and a trained group of volunteers who conducted door-to-door conversations about vaccine hesitancy, enabling the dissemination of reliable information. The door-to-door model was adapted from a model of community health nurses that would check on people who were self-isolating.

The vaccine rollout also uncovered pre-Covid disparities and marginalised groups. During community outreach efforts, residents were found who said they were 'barely managing' both before and during the pandemic. The intense door-to-door engagement in Oldham meant that disenfranchised residents could be reached and access support.

Faith organisations

Faith organisations played an important in drawing various community groups together. 'Pop-up' vaccination clinics in mosques and community venues were successful at ensuring the vaccination programme reached a large number of community members.

Social media was used to combat faith-based hesitancy; Tik Tok and Instagram were used to publicise 30 Imans being vaccinated. Faith groups were consulted in the design of vaccine messaging. In faith-based communities, successful engagement saw hesitancy rapidly change to demand - often in a matter of 24 hours.

Community cohesion

Oldham has long experienced marginalisation and been considered by some as a 'problem borough. Some studies point to Oldham becoming increasingly marginalised in comparison to the success of the City of Manchester and Greater Manchester Combined Authority. Workshop participants had an awareness of Oldham's position and status in relation to other nearby areas.

Local organising efforts were mobilised from an awareness of being considered 'the underdog'. Oldham's public health systems and institutions, clinical commissioning groups, civil society and community health system took a highly committed and collaborative approach to delivering the vaccine rollout. Workshop participants expressed a heartening sense of pride and solidarity that had emerged during the pandemic and the vaccine rollout.

"I have found this meeting so inspirational and it has really showcased the work that has been done and how far we have come in Oldham - WOW I'm so proud to work and live here."

'One Oldham'

Oldham's longstanding reputation for different communities 'living separately' and of polarisation on the grounds of race, was a key theme in the workshop. Although the 2001 'race riots' were not explicitly mentioned in the workshops, participants drew on racial segregation which originated from the demise of Oldham's industry and economic restructuring. The vaccine rollout was seen by many as an opportunity for healing tensions. The collaborative community efforts to support vaccine rollout were successful as engaging smaller ethnic minority groups, traversing language barriers, and building connections both across and within different communities.

The manner in which different faith groups, civil society organisations and leaders of different communities mobilised to deliver vaccine engagement lays a promising foundation for stronger community cohesion. However, workshop participants were unsure whether their optimism about the success of collaboration and cross-community engagement was shared by the communities they represented.

"I agree with my colleague, where CCG, Trusts and LA are more together than we were, the population we serve are probably less convinced of improved integration."

The experience of collaboration and partnership building during the pandemic has the potential to be transformative in Oldham. It is a significant opportunity to address greater concerns of cohesion, discrimination and indeed, the risk of future social unrest. This opportunity needs to be recognised and capitalised on in order to deliver lasting change and much needed positive social and community outcomes in Oldham. It is vital that this potentially transformative opportunity is not squandered by lack of resource and investment.

Discussion: the 3 C's

A 2014 report by the World Health Organisation (WHO) on vaccine hesitancy proposed the now influential '3 Cs model': confidence, convenience, and complacency as key in determining vaccine hesitancy.

Complacency & convenience

These themes do not seem to be a salient factor in the case of Oldham. This may be because of the strength of a fourth 'c', that of 'community'. Community has been a strong driver of a successful vaccine rollout, one that is especially highlighted in light of the emergence of the working groups in response to an unpredictable supply to vaccines and PPE. Collaborative community efforts around vaccine rollout created a hyper-localised and trusted response. This enabled the successful delivery of pop-up clinics and resources to enable vaccine rollout.

Confidence

The theme of confidence came out strongly in the community workshops. There was evidently a deep distrust amongst Oldham residents of the Government. Given the history of Oldham's marginalised groups and racial conflicts, there was clear tensions around Pakistani and Bangladeshi communities being vaccinated first. Cohesion thus emerges as a strong sub-theme which needs further investigation in the context of public health. Community has been a foremost factor in driving uptake, yet Confidence issues have at least in part been foregrounded by racial tensions.

Finally, a fifth 'c' 'communication' has also been very important to the success of vaccine rollout in Oldham. Communication from National Government was limited and untimely. In contrast, the local, human based interaction and communication of the working group was facilitative of higher vaccine uptake.

Conclusion

Looking to the future, participants had a great deal of pride in the unique local infrastructure that had orchestrated the vaccine rollout. However, there was a fear that this infrastructure would disintegrate when moving 'from war time to peace time'. There was a strong desire to keep the effective links and bridges, but a pervasive concern that the incentive to do so would gradually decline.

There was also significant concern expressed about the scale of other health care crises that had accumulated over the pandemic. Over 19,000 people waiting for elective surgery in Oldham. Residents were coming to GPs with 4 or 5 things issues that had developed over the last year and the prevalence of mental illnesses in Oldham residents had increased.

Oldham has a unique opportunity to build on the transformative experience of collaborative community delivery during the pandemic. It is important that the strong partnerships and practical experience are consolidated in order to enable Oldham to rebuild in a post-pandemic world.

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This research is funded by the British Academy, the Social Science Research Council and the UK's Science & Innovation Network in the USA.

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