



UK Health
Security
Agency

Evaluation of the enduring transmission pilot in Peterborough, Fenland and South Holland

Final report

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Introduction

This is the final report for the evaluation of the Fenland, Peterborough and South Holland Enduring Transmission Pilot (the pilot), one of a series of coronavirus (COVID-19) self-isolation pilots funded during 2021. The evaluation was undertaken by ICF on behalf of the Department for Health and Social Care (DHSC) and was completed in 2 stages:

1. A qualitative process evaluation stage tracked the main period of pilot delivery from June to September 2021. Chapter 2 of this report explores pilot implementation. Chapter 3 captures lessons from the qualitative research in the context of the pilot's upfront objectives.
2. An impact evaluation stage was undertaken in early 2022. It assessed delivery over a longer period from June to December 2021, reflecting that the pilot activity in scope of the impact evaluation, namely the provision of third sector support to individuals, continued until the end of the year and to allow the largest possible sample to form the basis of the impact analysis. Chapter 4 describes the data used for the impact evaluation, while Chapter 5 presents the empirical methodology and results.

The remainder of Chapter 1 provides an overview of the pilot and the evaluation approach. Chapter 6 sets out high-level conclusions based on the evaluation evidence.

Overview of the pilot

Pilot rationale and context

The pilot planned to take a system-wide approach to tackling entrenched COVID-19 transmission that was thought to be linked to 'both structural and cultural factors'¹ within the 3 local authority areas Fenland, Peterborough and South Holland. It was initially planned to deliver over a 3-month period from June to August 2021, although the timescale was subsequently extended first to the end of September 2021 (the main pilot period) and then in a reduced form (the provision of third sector support only) to the end of December 2021.

The pilot had a long gestation period. Plans initially emerged in late 2020 as a consequence of the evidence of enduring transmission in Peterborough and Fenland, initially. South Holland came on board later to offer experience of similar issues in an area with a slightly different industry composition.

The pilot bid document in April 2021 described a complex mix of factors that underpinned enduring transmission locally, including low job security among temporary and agency workers, transport to work in rural areas and housing conditions. At the time, this created a backdrop

¹ Pilot to address factors leading to enduring transmission in Peterborough, Fenland and South Holland: Bid Document 15.04.21.

against which some people were felt to be reluctant to come forward for testing and struggled to self-isolate for fear of losing their jobs.

The pilot sought to unblock these barriers to testing and self-isolation through a mix of financial and practical support measures, alongside work with employers and intermediaries to help create conditions in which workers are both willing and able to be tested or self-isolate.

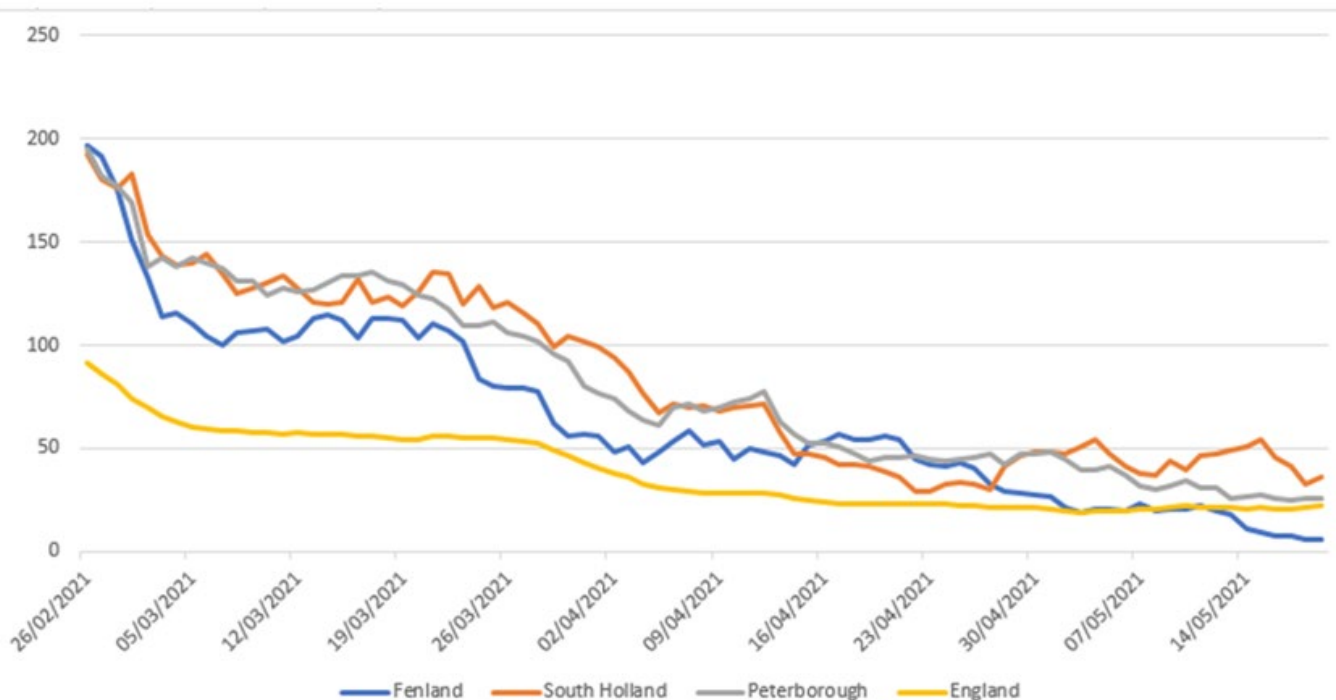
The pilot initially focused on promoting self-isolation and COVID-19-safe behaviours among low paid, often migrant, workers. The bid described its target individuals as:

“low paid workers often on zero-hour contracts who are employed in the food production, packaging or distribution, general warehousing and construction industries. These sectors are of particular concern given the transmission risks associated with an increase in seasonal workers (especially in food production and construction) over the spring and summer months, who play a vital role in the local economies.”

The target population expanded during the pilot delivery period, initially in terms of expanding the eligible target industries and, ultimately, in terms of removing the focus on particular industries beyond the main stage of delivery (that is, from October 2021). The evolution in target group focus during the delivery phase was partly a consequence of the transmission context changing locally from the initial conception of the pilot in late 2020 to the time the pilot started delivery in June 2021.

Figure 1.1 shows rolling case rate figures in the 3 participating local authorities moving towards the England average in the first half of 2021 – and below average in the context of Fenland – up to the point at which the pilot started. Case rates would fluctuate in the pilot areas over the latter half of 2021, but in ways that more closely mirrored the pandemic waves nationally. This arguably signalled that some of the local-specific factors underpinning what was seen as ‘enduring’ transmission in 2020 became less significant as the pandemic progressed. While the pilot cannot show categorically why this might have happened, it suggests something about how parts of the system might have adapted locally (especially in terms of the employer response and the labour market situation).

Figure 1.1 Rate of people with at least one positive COVID-19 test result, either lab-reported or lateral flow device (England only) per 100,000 population in the rolling 7-day period ending on the dates shown.



Source: [the coronavirus dashboard](#) (accessed 25 May 2021)

Planned activities and resources

The pilot budget was £2.6m, although it did not deploy this level of resources in practice.² It devised 5 interventions with associated enabling activities. These initial plans are listed in 'Annexe: Summary of planned pilot interventions'. All pilot activities were intended to be delivered across the 3 local authority areas. Each intervention included a mix of different types of activity and, depending on how these are segmented, it might be considered that the pilot was originally planning 15 to 20 different actions across the 3 areas. In terms of resourcing, these could be summarised as follows:

1. The provision of additional financial incentives to enable/support testing and adherence to self-isolation – representing an estimated 42% of pilot resourcing, and reflecting the main activities delivered in practice.
2. The provision of additional, COVID-19-secure transport capacity – representing an estimated 20% of pilot resourcing.
3. The provision of additional Gangmasters and Labour Abuse Authority (GLAA) and housing officer capacity for various 'Engage, Educate, Encourage and Enforce' activities with

² A cost-benefit analysis (CBA) of the pilot was separately undertaken by UKHSA in spring 2022.

employers, labour agencies, gangmasters, property owners and associated cases across the different interventions – representing an estimated 17% of pilot resourcing.

4. Operational costs to manage the partnership/programme, including additional enforcement and enabling activities – representing an estimated 12% of resourcing.
5. Costs of administering a new model for the provision of financial payments via a third sector organisation – representing an estimated 8% of resourcing and underpinning activity that was delivered in practice.

The pilot was formative in nature. During its delivery period, the pilot 'offer' adapted to reflect what had been found to work and what would be feasible to deliver. As noted above, the target group also evolved to reflect need. The pilot in the end was therefore somewhat different to what was initially planned, though in part this was a consequence of ongoing learning and course correction during implementation.

Evaluation objectives and method

The aim of the study was to evaluate the effectiveness and impact of the enduring transmission pilot being implemented in Peterborough, Fenland and South Holland. The main evaluation tasks undertaken are summarised in Table 1.1.

Table 1.1 List of evaluation tasks

1. Pilot early implementation and establishing the evaluation
2. Key 'delivery' organisation first stage qualitative interviews
3. Data set up (cleaning and deriving variables)
4. Employer/intermediary and delivery organisation second stage qualitative interviews
5. Impact analysis
6. Project governance observations and pilot evaluation co-creation
7. Reporting (emerging and final)

Initial objectives

The pilot, in conjunction with the DHSC, developed a summary evaluation framework, which is shown in 'Annexe: Original pilot summary evaluation framework'. It was used as the starting point for evaluation design and showed the pilot planning to test multiple hypotheses and via a complex interaction of inputs, outputs and outcomes. The initial objectives in this context were to:

- evaluate whether providing improved access to Test and Trace £500 support for self-isolation payments (support payments) through a third sector organisation with strong links to the target communities increases testing rates and increases adherence to

self-isolation – as described below, this objective in a partial form³ became the main focus for the impact evaluation

- evaluate whether additional activity to target employers who use agency labour, as well as agency and gangmasters, can provide additional contract security for workers that increases testing and adherence to self-isolation behaviours
- evaluate whether providing safe transport (bus services) increases the level of COVID-19-safe behaviours among low-paid agency and rural workers in target sectors
- evaluate whether a system for property owners to be paid the rent of workers required to self-isolate, via the third sector organisation, increases testing rates and increases adherence to self-isolation
- evaluate whether the provision of COVID-19-self accommodation increases adherence to self-isolation

As the pilot was “adopting a holistic, system-wide approach [in which] all the barriers are addressed simultaneously”,⁴ the evaluation also planned to explore 2 cross-cutting dimensions:

1. The effectiveness of the process of implementing a systems-wide model of ‘enablers’ that mobilises input from across the local authorities, GLAA, housing officers, public health teams, local contact tracing teams, public transport marshals, health and safety teams, third sector and community organisations, via programme and delivery groups responsible for the governance of the pilot.
2. The combined effect of actions to ‘engage, educate, encourage and enforce’ target employers and associated labour agencies to engender COVID-19 minimising behaviours and actions through intermediate measures of positive engagement with the pilot, compliance with GLAA licensing standards and use of employer-led home and site lateral flow testing is intermediate outcomes supporting positive impact.

A streamlined evaluation focus

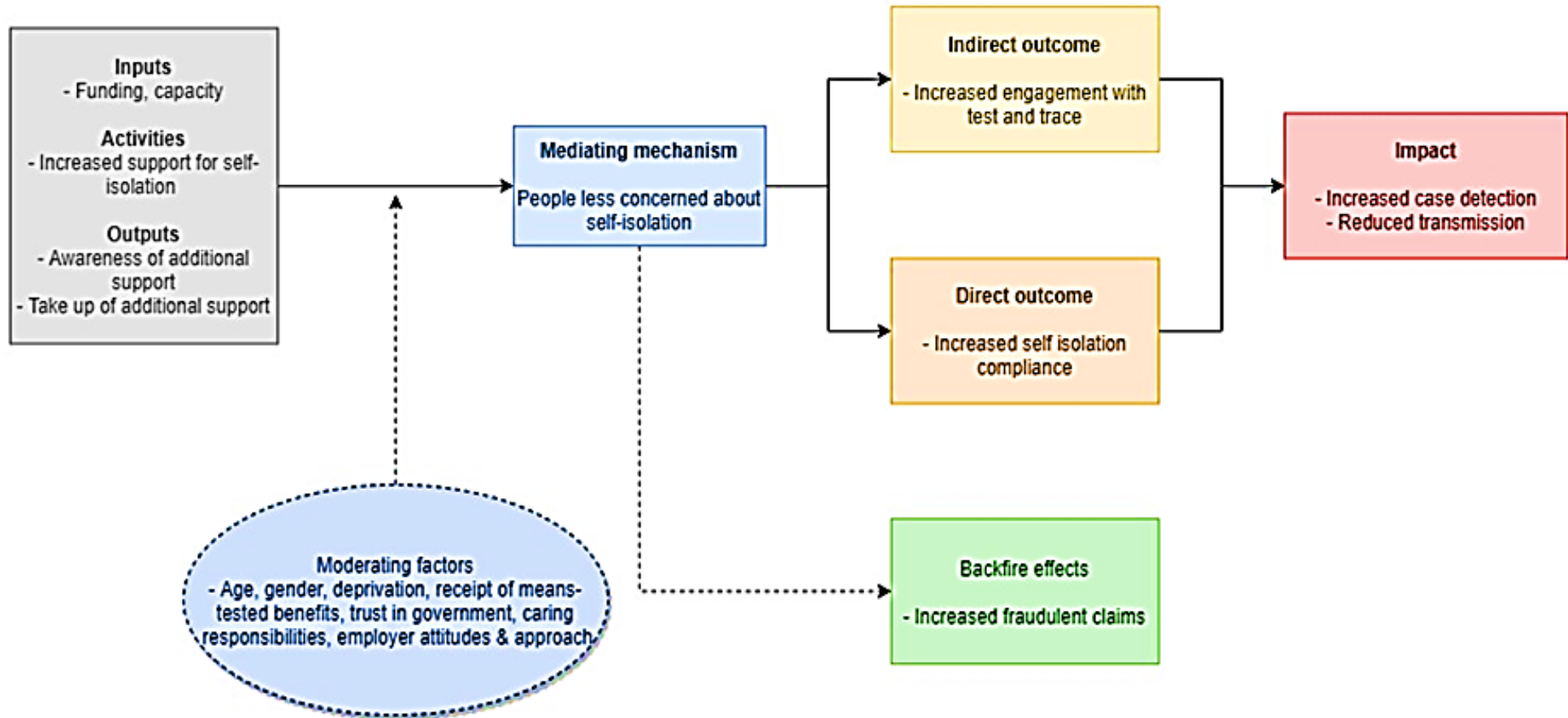
As the pilot evolved, it became apparent clear that not all of these objectives could be evaluated. Some activities were de-prioritised and determined to be unworkable in practice. However, there was still considerable learning from the pilot’s work to determine which activities gained traction and why.

In reality, the streamlining of planned activities simplified the pilot intervention logic and brought it closer to the Department’s original programme-level theory of change for the self-isolation pilots in context of having a mediating mechanism (improved access to support) linked to the direct outcome of increased compliance, as shown in Figure 1.2.

³ In the context of self-isolation compliance rather than testing rates)

⁴ Bid: Pilot to address factors leading to enduring transmission in Peterborough, Fenland and South Holland (15 March 2021).

Figure 1.2 DHSC programme level theory of change



Source: DHSC

Text version of Figure 1.2. DHSC programme level theory of change

Step 1

Inputs: funding, capacity

Activities: increase support for self-isolation

Outputs: awareness of traditional support and take-up of additional support

These may be affected by moderating factors such as: age, gender, deprivation, receipt of means-tested benefits, trust in government, caring responsibilities, employer attitudes and approach.

Step 2

Mediating mechanism: people less concerned about self-isolation.

This leads to 2 types of outcome:

1. Indirect outcome: increased engagement with Test and Trace
2. Direct outcome: increased self-isolation compliance

It can also lead to backfire effects such as increased fraudulent claims.

Step 3

Both indirect and direct outcomes lead to 2 impacts: increased case detection and reduced transmission.

End of text transcription of Figure 1.2

The process evaluation used semi-structured interviews to gather explanatory insights on the development and delivery of pilot interventions (the process of delivery, evidence of promising practice), as well as to source and gather pilot Management Information (MI) on delivery based on the pilot's own KPIs. Interviewees included a mix of employers and stakeholders involved in pilot delivered (listed in 'Annexe: Qualitative research interviews').

The impact evaluation ultimately focused on whether providing improved access to support for self-isolation payments (support payments) through a third sector organisation increased adherence to self-isolation. It used the National Test and Trace CTAS data set linked to pilot MI data. As the pilot was established as an area-level intervention, we initially envisaged that the impact evaluation would cover all individuals residing in the 3 Local Authority Districts (LADs) where the pilot was rolled out (namely, Peterborough, Fenland and South Holland).

However, the low number of individuals who underwent treatment in these areas over the period June to September 2021 (around 250 people were recorded in Rosmini's Management Information system as having been supported) meant that such an area-level analysis would not have been appropriate to capture the pilot's impact.

Acknowledging that an impact evaluation of the pilot should emphasise the individual nature of the pilot's support, we decided to estimate the impact of the pilot on treated (rather than the wider population of eligible) people. The impact evaluation uses Coarsened Exact Matching (CEM) to identify a comparator group of individuals who did not receive support from Rosmini ('untreated' or 'non-supported' individuals) and who are similar to supported individuals. It estimates impact as the difference between the post-treatment outcomes (outcomes measured after receiving support) for supported individuals and this matched comparator group.

Process evaluation: implementing the pilot

Early implementation in a changing context

The pilot was originally scheduled to run over a 3-month period from June to August 2021. It was extended until the end of September to account for challenges in initial mobilisation. This can be considered the main phase of pilot delivery and was the focus of the qualitative research.

While the provision of third sector support continued during October to December 2021 in an extended phase (which forms part of the impact evaluation analysis presented in Chapters 4 and 5), it was the main phase of the pilot that was attempting to test the system-wide approach to increasing COVID-19 self-isolation and reducing transmission (the activities, outputs and outcomes set out in 'Annexe: Summary of planned pilot interventions' and 'Annexe: Original pilot summary evaluation framework').

The original pilot model put employers front-and-centre as the providers of referrals for financial support. While preparatory work was undertaken before the launch of the pilot in June 2021, there was a limit to how extensive this work could be and the engagement work with employers had a longer lead time in practice. This meant June was primarily focused on pilot set-up in the context of having an employer-driven and system wide model rather than being Month one of a 3-month pilot delivery. It is not clear how this set-up work could have been foreshortened, so the initial extension of the main phase to September made sense.

There was also evidence that the nature of demand for support was evolving around the time that the pilot launched related to a series of factors, which substantially affected early implementation:

The COVID-19 transmission backdrop: Changing COVID-19 transmission rates over spring and summer 2021 affected case numbers and overall demand for support, especially during June and July (although referrals increased in August). As a factor affecting pilot demand, this was arguably a less significant factor than the referral model itself, which depended on employers as the intermediary. The evolution of the model for providing support (eligibility; referral routes) and the interplay with take-up is set out below in Section 2.2.

The changing labour market context: The qualitative interviews consistently suggested differences in the composition of the labour market in 2021 compared to 2020 meant that there were fewer migrant/seasonal workers employed via labour agencies/gangmasters. This was key target group for some pilot strands and meant that key components of the system-wide approach could not be delivered. This is discussed in Chapter 3 in the context of wider lessons, but activities not delivered in a substantive sense were:

- rent payments for people not eligible for Test and Trace and local discretion payments
- providing assurance of job security, and working with labour providers or gangmasters to ensure contract security for workers
- supporting system-wide enabling activities, including: communications; worker buddies; community champions; and a whistleblowing arbitration process

Evolving employer preparedness and demand as the pandemic progressed. There were shifts in COVID-19 preparedness over time from employers (particularly large employers) in the sectors that experienced enduring transmission in 2020, changing the nature of employer support needs, especially in the context of the referral of individuals for financial support. This is discussed in section 2.4. It also contributed to some of the pilot strands listed above not being undertaken, as well as the safe transport strand taking much longer to mobilise than originally planned and at a smaller scale (discussed also in Chapter 3).

Third sector support delivery over the pilot period

Overview of referrals for support

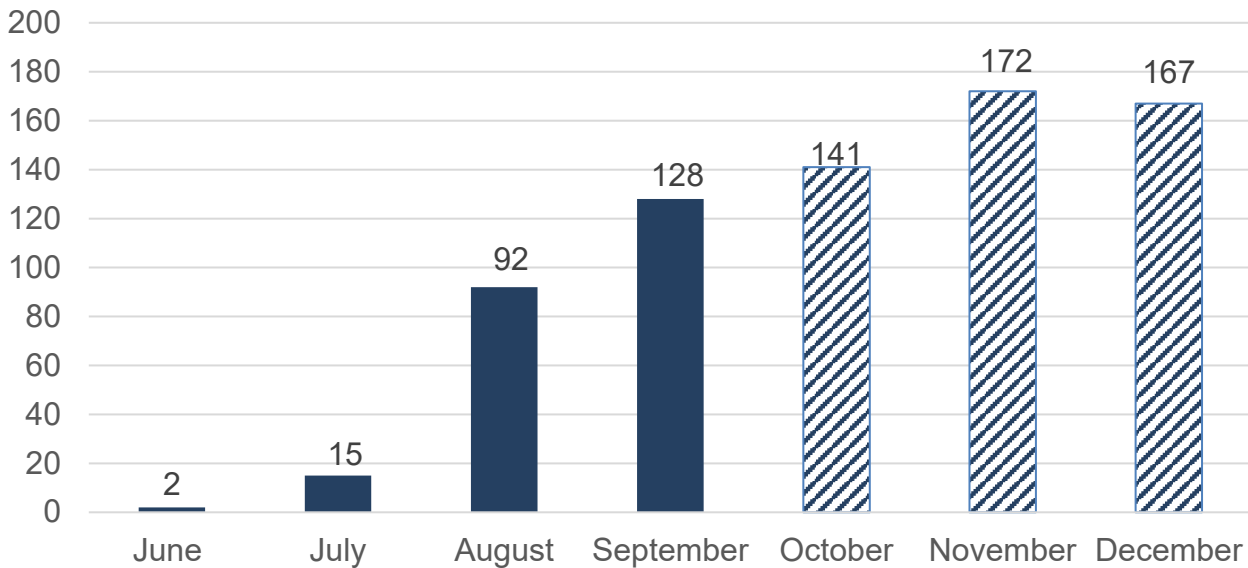
The first element of the pilot to be delivered and the main focus of overall delivery was the provision support for individuals in the form of help to access the £500 national payment and enhanced or alternative local discretionary payments

Figure 2.1 provides an overview of the number of individuals supported by month. The main phase of pilot period (June to September) is highlighted in blue and shows a total of 237 supported individuals. The extended phase is shown in orange and included a further 480 support individuals. The chart shows that the number of referrals increased over time and there was continuing demand well beyond the main delivery phase. A total of 717 individuals were supported from June to December 2021.

Rosmini, the third sector organisation providing support, was an established partner based in Wisbech and well embedded in some of the pilot local authority areas. It was therefore able to mobilise quickly. However, there were only 2 referrals in the first month, which was a consequence of 2 related factors:

1. Rosmini was not initially engaged in marketing the offer of support directly to communities, meaning that the pilot was initially dependent on external parties (participating employers) for referrals.
2. The arrangements with employers to participate in the pilot and make referrals were still being set up while the pilot started delivery

Figure 2.1. Pilot referrals supported by month



Source: ICF Analysis of Pilot MI

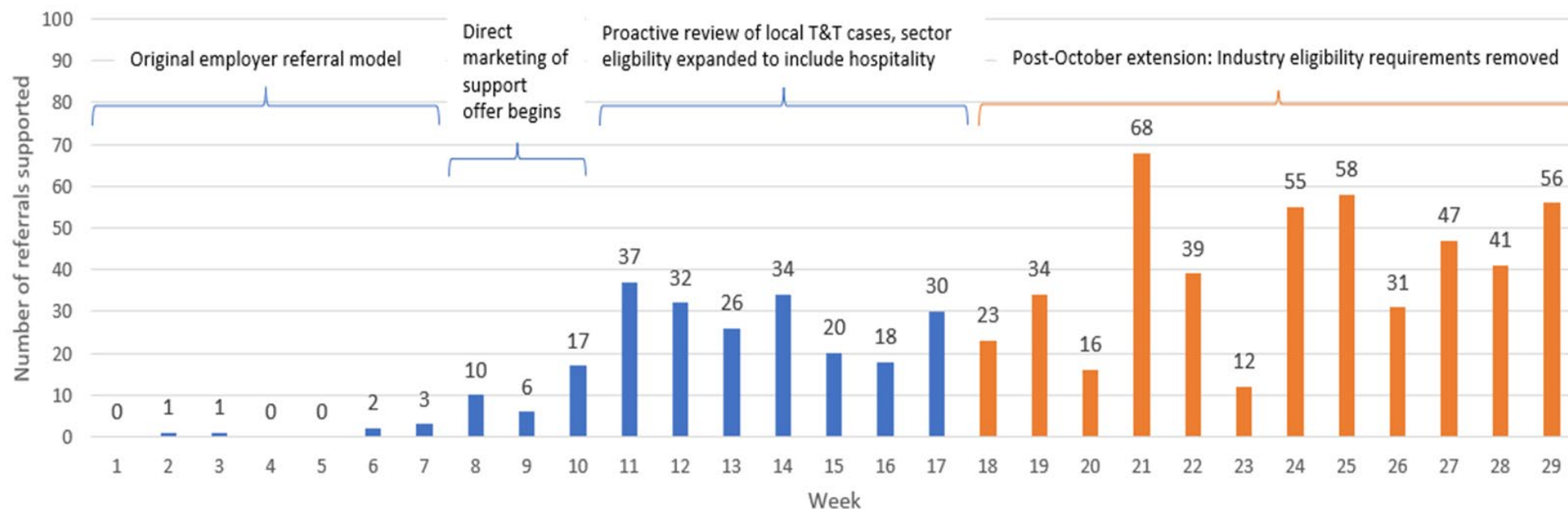
The impact of evolving the support model

The growth in referrals over time was not simply a function of the pilot becoming more established. It reflected a major shift first in the referral model and then in the eligibility criteria. Figure 2.2 shows the number of eligible referrals supported by week in the context of the evolving model.

The original employer referral model led to few people being signposted for support. From Week 8, Rosmini was able to market the ‘offer’ more directly to the community/employers and, crucially, from Week 11, it and the pilot team was proactively engaging potentially in-scope referrals from Test and Trace team data. This phase also included the extension of the pilot to the hospitality sector, which provided a material difference in the scope to provide support. Adapting the referral model to enable both the pilot and Rosmini to engage more directly with the community (as well as expanding the in-scope population) has therefore had a considerable impact on delivery.

In the extended phase of delivery, from Week 18, the industry eligibility was removed, acknowledging that once employers were no longer seen as the main route for referral, having an industry-focused pilot within a local area made little sense. It could never align with need at any point in time and arguably made determining eligibility more complex.

Figure 2.2. Pilot referrals by week mapped to the evolving support delivery model



Source: Pilot MI

Delivery across 3 local authority areas

Co-designing and coordinating the delivery of the pilot across 3 different local authorities was reportedly challenging. It required co-ordination across multiple departments within each local authority (housing, benefits, environmental and so on) and multiplied the complexity of this from an organisational perspective by attempting to link 3 local authorities that do not necessarily operate in the same way.

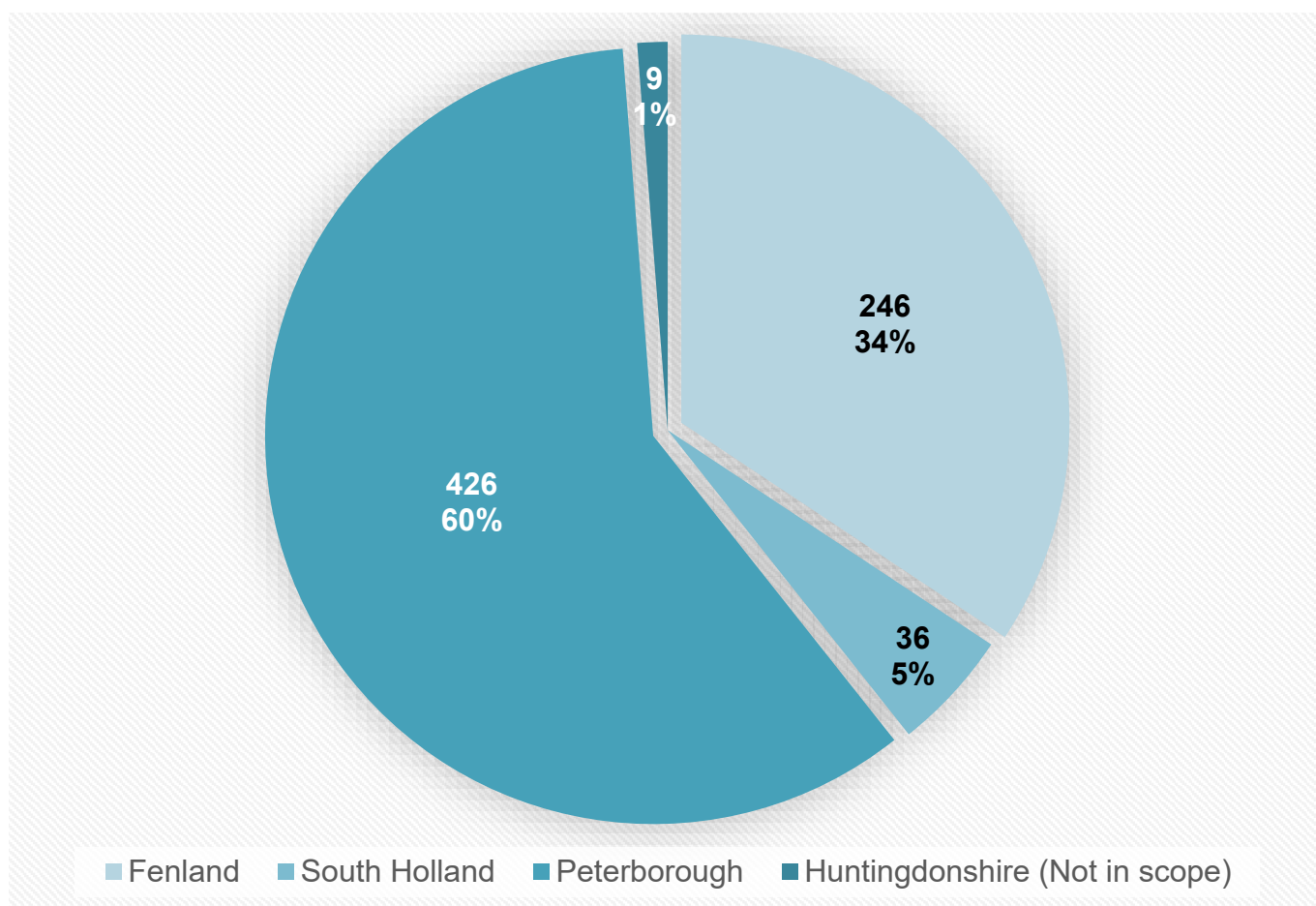
While 2 of the local authorities (Peterborough and Fenland) sit in the same county and had a recent pre-history of joint working, this was not the case with South Holland. This meant that ways of working, trust and shared understandings had to be built up over time. It is also demanded considerable organisational effort. There were weekly delivery group meetings in the main phase to discuss progress and agree actions with 15 or more members.

Appointing dedicated leads for each of the pilot elements was reported to have provided additional resource for cross-local authority coordination and helped to galvanise or accelerate implementation. Nevertheless, the qualitative evidence from multiple different perspectives indicated that adding South Holland to the pilot after considerable development work had already been undertaken inevitably created challenges in terms of the buy-in required to quickly mobilise. Even though there were geographic similarities between South Holland and Fenland and the ambitions of the pilot were shared across all areas, the different structures remained a barrier throughout.

There were fewer referrals in South Holland. The pilot's own analysis in September 2021 of the first 150 referrals indicated that 90 came from Peterborough (60%), 45 from Fenland (30%) and 10 from South Holland (7%). The location of 4 cases (2%) were to be confirmed.

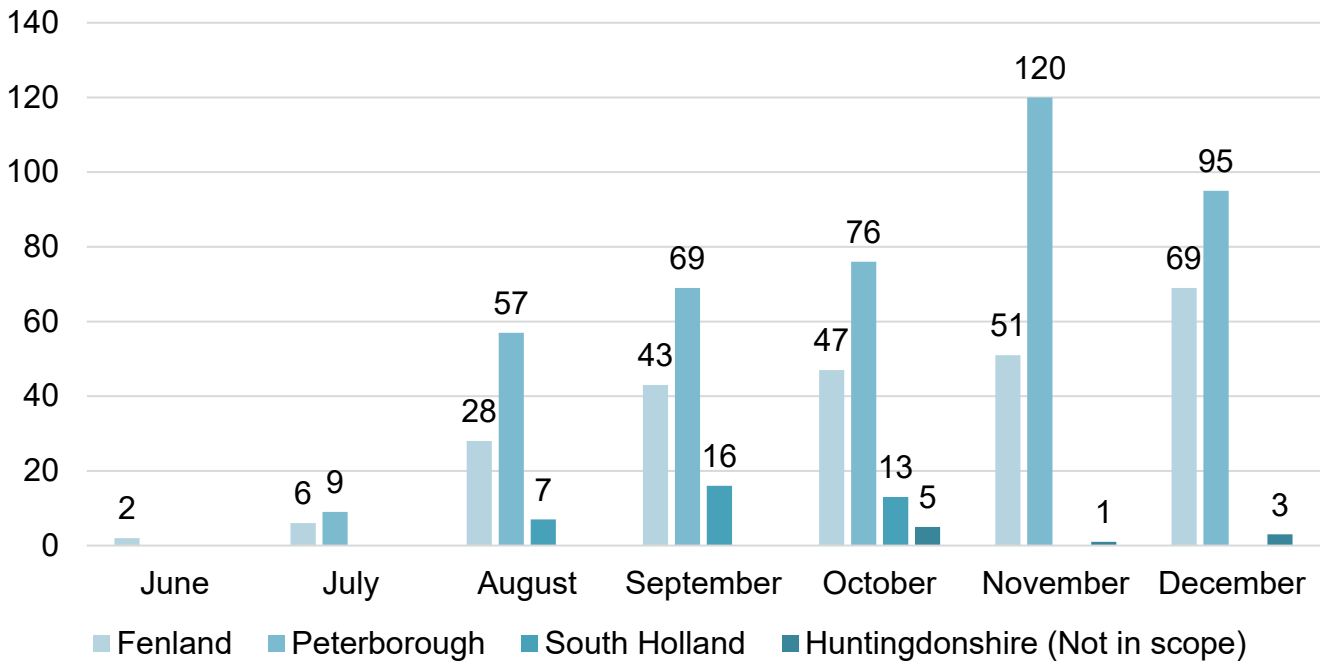
ICF postcode analysis of all referrals over the June to December period shows that this pattern of take-up by local authority area was similar over the longer-term (Figure 2.3). It is not simply that engagement in South Holland took longer to ramp-up. Figure 2.4 shows that all referrals from South Holland came in 3-month window, even accounting for the extended phase.

Figure 2.3. Total pilot referrals by local authority area (June to December 2021)



Source: ICF analysis of pilot MI

Figure 2.4. Pilot referrals by local authority by month (2021)



Source: ICF analysis of pilot MI

Employer engagement

There was extensive engagement with employers by the pilot. An initial employer engagement exercise in June/July proved partly successful, with 32 local employers signed up against a notional target of 40 to 50. A further 7 businesses were then engaged in the hospitality industry. This did not, though, generally translate into concerted joint action. Areas of focus such as transport to work and housing still mapped to employer concerns (giving some credence to the pilot’s initial scope of action). Safe transport support required considerable preparatory work to mobilise. The housing issues appeared to be beyond the perceived direct role of employers.

There was a fairly even balance of businesses engaged across the 3 local authority areas. According to pilot MI, the average size of employer in the original cohort was about 350 staff (with a considerable mix between permanent and agency staff). The hospitality businesses were generally smaller (about 25 staff on average and typically permanent staff).

The impact of the evolving COVID-19 context

The situation in terms of employer preparedness for identifying and managing COVID-19 cases appeared to have changed substantially since 2020. Employers playing a direct role in referring cases for additional support was not a priority in practice beyond signposting. This appeared to reflect a mix of overall case numbers, timing and the extent to which employers feel limits to their role intervening beyond the workplace. The businesses in scope of the pilot (excluding hospitality) generally stayed open during the pandemic and put their own measures in place. So, the lack of practical collaboration was partly about timing:

“We probably needed it earlier, like last summer.”

“The ideas were great but probably 6 to 8 weeks too late to make a difference.”

Several employers reported that they had introduced their own financial and other measures as the pandemic had developed, which lessened the demand/need for some intended elements of the pilot. One employer with established workforce safety controls (hygiene; random testing) described itself as simply being “very lucky” not having experienced an outbreak. As such, having the time to prepare and having experienced low case numbers combined to influence demand for direct support from the pilot.

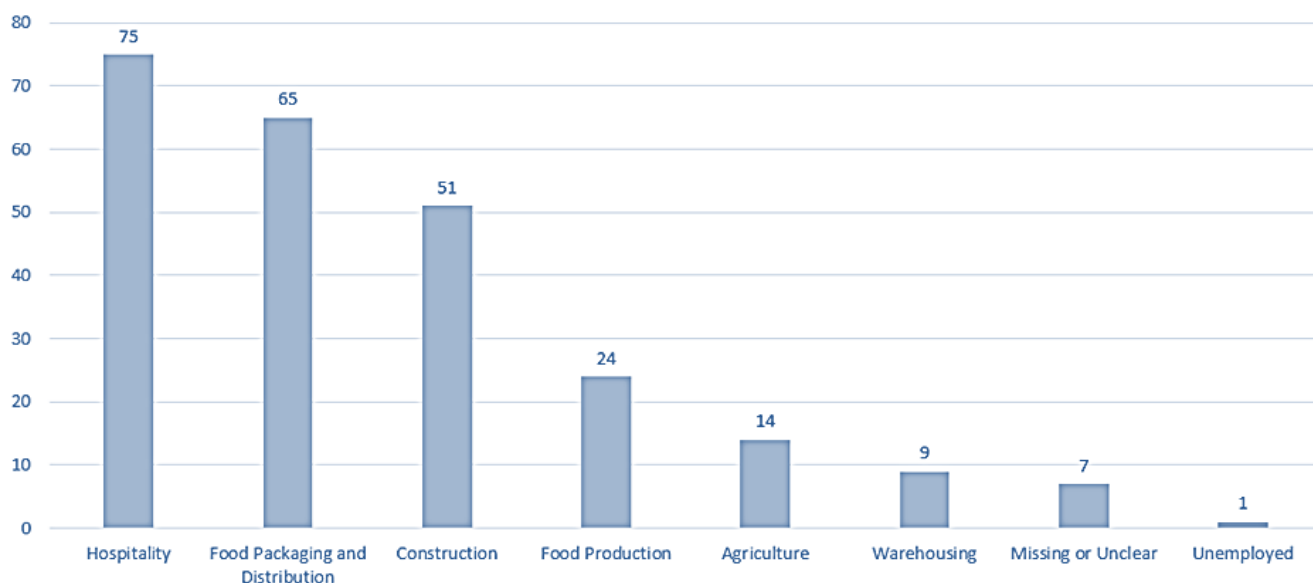
Experiences reported by some, such as having up to 20% of staff self-isolating or having a significant outbreak were exceptional in summer 2021. These situations had serious business impacts but did not appear to form the basis for needing more extensive support at the time.

More pressing issues reported were general labour shortages, which appears to transform the calculation for employers who became more concerned about losing staff if they did not provide support to self-isolate. Employers did appear to be more circumspect in terms of support for agency workers. Permanent staff were generally being financially supported and case numbers were generally low. Some employers reported little reluctance among permanent staff to self-isolate. One employer with a considerable agency workforce painted a different picture, but described a complex mix of factors contributing to reluctance to self-isolate (peer pressure; cultural norms etc).

Take-up by sector

The pilot originally targeted the food production, packaging/distribution, general warehousing and construction industries. It was expanded to include the hospitality industry based on the logic that this sector contained similar characteristics, as well as seeing increased cases. The pilot’s own analysis of the eligible cases referred for support to Rosmini up to the end of September (see Figure 2.5) shows that, even though the inclusion of the hospitality came later, it already represented a substantial share of individuals benefitting from support by the end of the main pilot phase.

Figure 2.5. Pilot support provided to individuals by industry (June to September)



Source: Pilot analysis of referrals to the end of September (main phase of delivery)

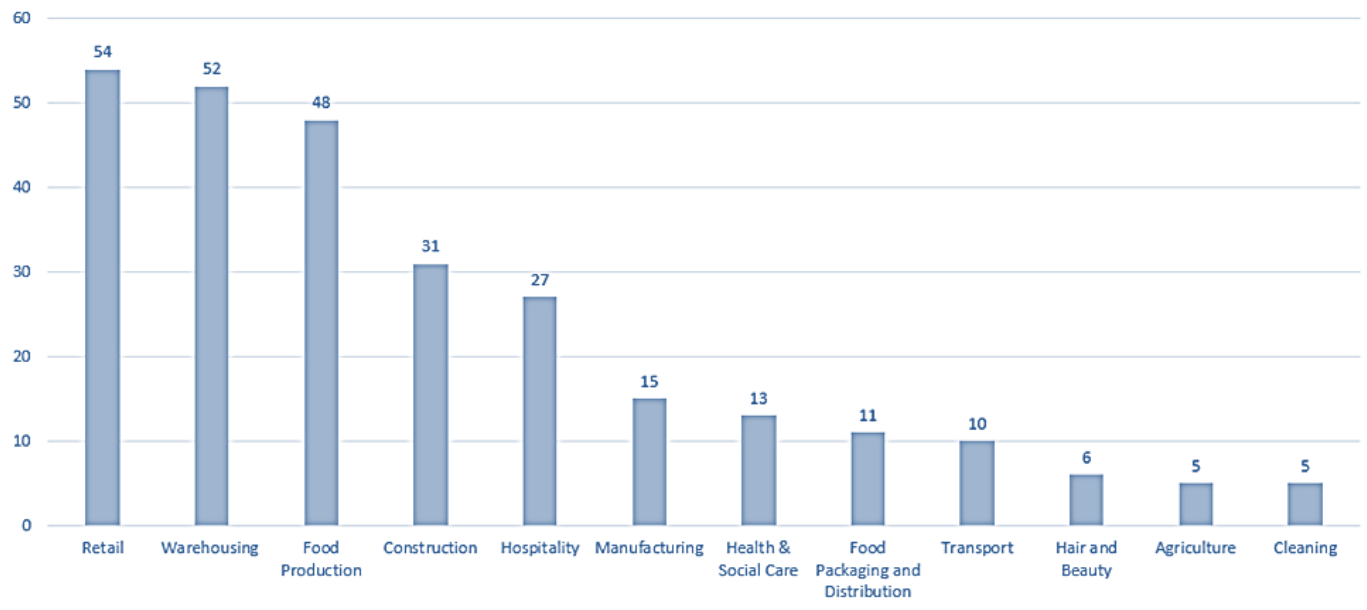
After September, the industry eligibility criteria was removed. This contributed to an increased overall level of support provided and shifted the profile of support somewhat. In the transition after the main pilot period, sector of work was not recorded for all individuals – although the gaps are periodic (a hiatus in recording) rather than systematic.

Figure 2.6 shows the wider mix of sectors supported in the extend phase. There is a long tail of small numbers of people supported from other industries ranging from childcare and education, through to security, fitness and leisure and financial services. This indicates that the expansion of the industry coverage more closely aligned the support offer with demand. Major local sectors initially envisaged as part of the pilot, such as warehousing and food production, still remain prominent, although the large retail sector accounts for the largest number of individuals supported in the extended October to December period (18% of all individuals where sector is known).

Looking at the overall data from June to December, while the similarities between the 3 LADs formed part of the pilot rationale, there were slight differences in take-up by industry in each area:

- the top 3 industries in Peterborough were hospitality (21% of coded referrals), warehousing (15%) and food packaging and distribution (14%)
- the top 3 industries in Fenland were construction (22%), food production (18%) and hospitality (17%)
- the top 3 industries in South Holland, where there was a much smaller number of referrals overall, were food packaging and distribution (38%), construction (33%) and agriculture (19%)

Figure 2.6. Pilot support provided to individuals by industry (October to December)



Source: ICF analysis of pilot data. Note that 292 out of 480 individuals supported in this period had sector of work recorded

Support provided in practice

The most tangible employer engagement in practice during the main phase of pilot delivery was support for onsite testing. This was part of the original menu of proposed activities, but perhaps rose to greater prominence in a way that reflected the changing landscape of employer needs. By mid-August, the pilot had facilitated online testing for over 120 employees at one employer (effectively incentivised with financial voucher payments to employees).

Employers cited their greatest need in summer 2021 to be around vaccination, with vaccine hesitancy reportedly common amongst migrant employees. The pilot was not designed to directly address this, but pilot staff used their wider links with other local services to help employers access other local support around vaccinations.

While the number of eligible referrals for financial support was low in some target industries (notably food production), this partly just reflected that these businesses had moved on (“they haven’t waited for the pilot”) in terms of the support they directly provide (for example, full pay for staff required to self-isolate). However, even in these cases, support around testing and communications was often welcomed.

This might show what a system-wide approach looks like in practice in terms of working with employers to ensure that staff who test positive are aware of the help available (see Figure 2.7 for an example of the type of poster-leaflet used). The pilot was also able to badge national information with local support contacts, as well as to translate information into multiple languages in order to extend reach to those who need it (that is, workers who may struggle to navigate the support application system).

Figure 2.7 Example pilot employee communications



We can help you to self-isolate

Extra support is on offer so you don't lose money

Your company is taking part in a project to offer extra support to employees to reduce the spread of Covid 19

We know that many people find it hard to self-isolate because of the loss of money – we can make sure you don't lose money.

You are part of this offer even if you are employed here via an agency.

You will not lose any money if you:

- Have to isolate because you or a close contact tests positive for Covid-19.
- Have to stay off work to look after someone such as a young child who has to self-isolate.
- Are unable to work whilst you wait for test results.
- Support we can offer includes:
 - An instant £150 for any lost days of work whilst you wait for test results.
 - Help with benefit applications if applicable.
 - An additional top up to match your wages if you do test positive and must be off work.

Support and advice is available in English or your own language.

! If you test positive, think you may have Covid-19, or a close contact tests positive, please speak with your supervisor who will refer you to the scheme.

You can call Anita on 07724 352627 or Mika on 07724 353119 at the Rosmini Centre or email covid19.rcw@gmail.com for more information

Further offers of support will be available soon



As the pilot scope expanded by sector, there was ongoing work to engage different types of business, particularly to cascade information about the support available. For example, there was engagement with Pubwatch in Peterborough to piggyback on meetings in which the

hospitality industry was already convening in order to promote the available support. The ability to track locally collated data on workplace cases allowed the pilot to identify and target sectors where the need was greatest. What the pilot ultimately developed was a capacity to link to existing networks to target these industries (where possible), alongside material to provide to these businesses for awareness raising/signposting purposes, and the underpinning support service itself.

Process evaluation: lessons

Providing financial support

The delivery of the support by a third sector organisation with good links to the local migrant community (and relevant language skills) was widely being seen as being an effective approach. Rosmini was able to mobilise quickly in principle because it was well-embedded. It was able to play this role even though the target group profile was different to that originally anticipated (because there were fewer migrant workers in 2021). The only caveat related to coverage across the 3 local authority areas, given that Rosmini did not have a physical presence or such close links in all 3 of the local authority areas. This probably said more about the appropriate reach for this kind of locally embedded pilot rather than anything about the Rosmini capability per se.

Rosmini brought language capability plus capacity to provide direct support to individuals needing financial assistance to self-isolate. This support was proactive and appeared to be extensive in practice (multiple follow up calls and reminders to ensure applications for support are completed). Upfront investment to set up the payment system so that emergency funding could be provided clearly worked.

The referral model

Broadening the referral model was a sensible approach as it reduced dependency on employers (initially envisaged as the main referral route) whose priorities and needs had evolved over time. The pilot's own data indicated that the business with the highest number of referrals equated to 7 referrals. There was one business with 5 referrals and several with 3 referrals. Demand in practice was more diffuse and rooted in sectors with smaller businesses, such as retail and hospitality.

The original referral model was high risk in terms of the reliance it placed on a substantial number of these employers both having cases and being willing to actively refer. In this context, the potential for self-referral and referral via contact tracing teams (while maintaining the eligibility criteria for support) likely increased the ability of the pilot to be able to test its support offer.

Most referrals came via pilot or local authority staff identifying potential beneficiaries from the data shared by the Test and Trace teams, as well as through marketing to the community. The pilot delivery group estimated that out of the 90% of supported cases recorded as coming via contact training, the vast majority were the result of proactive interrogation of the data by the pilot team and subsequent referral to Rosmini. As such, variation in information provided by local Test and Trace teams to the pilot in each of the 3 LADs might also have contributed the number of referrals by area. In South Holland, for example, the pilot was only provided with a

name and telephone number, while in the other LADs there was other information that was felt to be helpful in judging potential eligibility upfront (for example, address; test date; employer information – where available).

Benefits to participants

The third sector support offer delivered by Rosmini offered added value in terms of:

1. Providing a more immediate response (emergency financial support) to individuals in need. This was partly a function of extensive early work to set up the payment model. There was also the suggestion that having the flexible capacity to directly support individuals through the system is what made the difference.
2. Being able to engage groups who may find it more difficult to deal with the local authority directly. There were a mix of factors reported here including language, trust and the level of existing links Rosmini had with the community. Its involvement was described by one interviewee as a 'no brainer' in this context. However, most people supported were not migrant workers and represented a much broader group in need. This encompassed individuals on low pay or zero hours contracts where there were barriers to accessing support, such as lack of IT, difficulties uploading documents, lack of access to internet banking and so on.

The pilot's analysis of referrals during the main phase recorded support as being provided to people across 10+ languages. More than 7 of out 10 (174 individuals) were English speakers. The next commonest languages were Lithuanian (24 individuals), Romanian and Polish (10 individuals each), Latvian (7 individuals) and Portuguese (6 individuals). There was then a long tail of one or 2 individuals speaking languages including Russian, Hungarian, Urdu and Greek.

The pilot undertook its own follow-up research with a small sample of 22 participants towards the end of the main pilot phase. A majority of these respondents heard about the pilot through 'word of mouth', with others typically being contacted by the pilot team and then forward on to Rosmini. Three-quarters (77%) of the sample 'reported a loss of monthly income as the key reason not to self-isolate', with fears of losing that job another widely reported fear.

The support typically provided by Rosmini to this cohort included help completing documentation to apply for financial support, as well as being able to access advice in a specific language. Notably, perhaps, the pilot's research with beneficiaries indicated that over half of respondents (59%) did not receive any financial or other support from their employer, while others only received SSP. This might indicate the while the employer interviews suggested that, by summer 2021, employer systems were often sufficiently developed for them to offer financial support directly to self-isolating employees, this was not the case for all employers.

The impact of the third sector support on self-isolation compliance is the subject of the impact evaluation component described in Chapters 4 and 5.

Providing rent payments

The original plan in relation to rent payments incorporated a mix of activities that intended to encourage actors within the system (notably gangmasters and labour agencies) to work with public authorities to identify individuals whose housing situation was such that the financial barriers associated with rent payment could reduce self-isolation compliance.

The ultimate hypothesis across all of these actions was that paying rent would influence testing take-up and adherence to self-isolation behaviours. The hypothesis was based on a set of assumptions not all of which were borne out in the changing employer/labour market context. The overall number of seasonal/temporary/migrant workers was lower than when the plan was conceived. Labour shortages provided an incentive for all actors in the system to exhibit some of the behaviours that this activity was intended to support in order to retain staff. As noted above, the support provided by employers (especially larger employers) was generally much more established than when the pilot was originally conceived.

There were also practical difficulties in implementing this approach that led the pilot to reasonably conclude that it was not worth pursuing:

1. Challenges in mobilising additional GLAA capacity and in working with labour agencies or gangmasters described below in Section 3.4 meant that the building blocks to identify candidates for rent support were not in place.
2. Furthermore, the pilot realised early on that while it was possible to set up a payments model through the benefits system, the idea of directly paying landlords added a level of complexity that was not workable in practice. In this context, it appears that facilitating access to financial support, including emergency support, under the financial security strand of the pilot was sufficient to address the fundamental need in practice.

Demand for COVID-19-safe accommodation

Plans to provide COVID-19-safe accommodation for those self-isolating in shared accommodation were decided to be impractical within the pilot timeframe and geographical constraints. This strand also depended on being able to mobilise the GLAA in a way that was not possible in practice.

However, a programme of targeted 'home visits' were designed and implemented from mid-August (for example, 17 visits completed in one of the pilot areas, Fenland, within the first 2 weeks). Housing officers conducted doorstep visits to individuals self-isolating to offer support and identify any unsafe/unlicensed accommodation.

The pilot reports that safe accommodation was available where necessary. Transmission risks associated with people living in Houses in Multiple Occupation (HMO) were noted by a wide variety of interviews. However, it appears that the solution provided (alternative accommodation) had little traction with individuals engaged and does not contribute to the

suggested outcomes. It may be that the experience here in the context of Peterborough, Fenland and South Holland is similar to other areas in which accommodation was offered to facilitate self-isolation.

Providing COVID-19-safe transport

The original plan involved establishing a network of COVID-19-safe public transport links across Peterborough, Fenland and South Holland for the transportation of agency workers and those living in rural areas to workplaces. This would encompass not only travel to and from work but also to support employers needing to send workers home after an onsite positive COVID-19 test. It included potential scope for an all-day bus service running across the 3 areas to accommodate different shift times and safe travel, marshals to travel on buses and to control queues at boarding point and police checks on private hire and cars on commuter routes.

Employers confirmed that car-sharing was frequent among many of their lower paid migrant worker employees and recognised the associated transmission risks. The pilot's original plan had been to commission a single local transport provider to provide COVID-19-safe transport across the 3 LADs. This evolved into a plan to deliver smaller-scale dedicated transport services for single employers. It reflected learning that, in practice, travel to work routes have to be mapped at the level of each individual employer.

There was a time lag in terms of contracting with the identified transport partner in each case. The pilot referred to the 'huge amount of effort' required to mobilise this strand of activity. According to pilot MI, 4 of the employers engaged signalled potential interest in being involved in the transport pilot, although this only translated into one concrete proposed service by the end of the main delivery phase.

While the transmission risks associated with transport were reiterated by employers – that is, it remained a real concern – the implied challenge for some employers as the COVID-19 situation evolved is that it only provided a partial solution in terms of minimising risks associated with worker movements post the re-opening of the wider economy (for example, groups of workers socialising).

Given this and the complexity of travel to work patterns in practice, it was not necessarily a priority investment of time for most employers to organise. Employers who retained an interest in participating in the safe transport strand did so because they viewed it as a positive 'offer' to retain staff in a tight labour market. The pilot's own reflection on the viability of this strand was that it could really only have worked at scale through labour agencies rather than employers. Even so, it was not necessarily a worthwhile offer in the long-term given the effort involved in set-up.

Providing additional assurance of job security

The pilot planned to test whether additional activity to target employers who use agency labour, as well as labour agencies and gangmasters, could provide additional contract security for workers that increased testing and adherence to self-isolation behaviours.

Whether the employer behaviour metric is valid or not (that is whether concerted effort to 'engage, educate, encourage and enforce' would lead to the anticipated outputs) it was not something that could be tested in practice by the pilot. There was, however, valuable learning from understanding why the hypothesis was not tested and, in particular, the extent to which the underlying rationale was quite context specific.

The evidence from 2020 that underpinned the original pilot plan suggested a series of work-related factors that may have contributed to enduring transmission locally at the time. These were directly related to employed patterns within the local areas, including a relative concentration of insecure work that might increase transmission. In essence, job insecurity meant that cases could not self-isolate and may increase transmission because of how individuals work across sites and employers in the identified industries. Anecdotally, this need appeared to have been recognised at the time by employers, gangmasters and labour agencies.

However, as noted above, by the time the pilot rolled out, many of the employers in scope had subsequently put their own measures in place. While these measures may not target agency workers in terms of support provided, the labour market shortages experienced by employers meant that the motivations and interests of employers and agencies were quite different in summer 2021. There were also fewer migrant workers who might instinctively fit into the target category in 2021 than in 2020.

A practical consequence of this was that gangmasters were more difficult for the pilot to engage, partly it was suggested because they had fewer workers. Labour agencies were engaged by the pilot but reported complying with their obligations. Much then rested on intended work with the GLAA through its enforcement role.

The pilot anticipated providing the GLAA with additional resource for roles supporting the pilot ambitions. A key learning point, though, was that providing resources to increase the capacity of an existing authority takes time and is not easy to mobilise. These roles required a specific skillset and experience that has proved difficult to recruit. The challenges in building this additional capacity were contrasted by stakeholders with the much-easier-to-mobilise model of bringing in an additional organisation to directly provide support for other aspects of the pilot (for example, Rosmini). The GLAA itself was also dealing with multiple priorities beyond the scope of the pilot (for example, combatting trafficking) and, as such, its scope for involvement in practice was more limited than planned – especially given the very different labour market context faced by the pilot in practice.

Impact evaluation: data

Data sources

The data used to quantitatively evaluate the impact of the third sector support provided by Rosmini was drawn from the following 2 sources:

The Contact Tracing and Advice Service (CTAS) database

This contains information about all cases (individuals who tested positive for COVID-19, either through a PCR or LFT) and their associated contacts (people whom cases reported they have been in contact with). An individual can have multiple records in the CTAS database as they can appear as a case first and a contact afterwards (or vice versa), be re-infected with COVID-19 (recorded again as a case) or be reported as a contact by different cases. For the purpose of the impact evaluation, we only focused on records for cases rather than for contacts.

Management Information (MI)

This was gathered by the pilot through the course of the intervention delivery. It contained information (key demographics, date of assessment and so on) about all treated individuals, that is, residents of the pilot areas who were supported by Rosmini.

Sample selection

The sample available for impact analysis included 228 treated people and 764,686 untreated people, all aged between 18 and 67. Below is an outline of how these 2 samples were achieved.

The treated group

A total of 717 treated people were included in the pilot's MI (individuals supported by Rosmini from June to December 2021). Of these, 504 individuals could be linked to CTAS data based on their postcode, gender, ethnicity and age (measured at assessment date). Among these 504 treated people, 276 could not be used for analysis for various reasons:

- 8 people were found to reside in untreated LADs
- 5 people were outside the age range considered
- 83 people had missing gender and/or ethnicity
- 137 people had a missing value for the outcome variable of self-isolation compliance; this was mostly the consequence of the day-10 call to landlines from the Test and Trace team to check compliance being discontinued from the 22 November 2021

- 43 people received the day-10 call before assessment date (the date at which Rosmini provided support according to the data), as such, the counterfactual-based methodology to estimate impacts was inapplicable to them

Removing these 276 individuals from the sample of 504 treated people linked to the CTAS database resulted in a final sample of 228 treated people. These 228 individuals were treated (supported by Rosmini) from the 23 June to the 22 November 2021.

The untreated group

The sample of 764,686 untreated people was obtained by considering all individuals aged 18 to 67 who resided in LADs other than Fenland, Peterborough and South Holland (after excluding all LADs where other Test and Trace pilots were rolled out), and with non-missing value on all the variables of interest (demographics and outcome).⁵

All untreated people were randomly assigned a pseudo assessment (treatment) date based on the observed joint distribution of test dates and assessment dates observed among treated individuals. ‘Annexe: Assignment of pseudo-assessment dates to untreated individuals’ provides a detailed explanation of the pseudo assessment date assignment process. The 764,686 untreated individuals used for impact analysis had pseudo start dates from the 23 June to the 22 November 2021 in order to match the range observed among treated people.

Descriptive statistics

Table 4.1 illustrates the sample size initially available for impact analysis. In total, there was full information (outcome of interest and key characteristics) for 764,914 individuals, of which 228 were treated and 764,686 untreated. This sample is referred to as the unmatched sample.

Table 4.1. Size of the unmatched sample

Treatment group	Sample size
Untreated	764,686
Treated	228
Total	764,914

Characteristics of the treated and untreated groups

Table 4.2 illustrates the characteristics of the unmatched sample separately for the treated and untreated group. It indicates where there were statistically significant differences between the

⁵ When multiple CTAS records were observed for the same untreated person, the latest record was used for analysis. This was done to maximise the number of comparators available as the majority of treated individuals were treated in later months.

treated and untreated groups. A statistically significant difference indicates that the 2 groups differ in terms of the characteristic in question.

The table uses the convention to denote statistical significance at the 1%, 5% and 10% level with ***, ** and *, respectively. It shows that the treated group contains a lower proportion of women than the untreated group. It is also characterised by higher proportions who are of white ethnicity and who reside in Lower Layer Super Output Areas (LSOAs) with high income deprivation (deciles 2, 3 and 4).

Treated people were, on average, almost 4 years younger than untreated people at assessment date (pseudo assessment date for the untreated people). The age variable was not normally distributed and therefore, in addition to testing the difference between the means of the treated and untreated group, differences between medians were also explored. The hypotheses that the distributions of the variables age and income deprivation rank are the same for the 2 groups was also tested and rejected (results not reported here).

Table 4.2. Characteristics of the unmatched sample

Characteristic	Untreated (unmatched)	Treated (unmatched)
Female (%)	54.42*	48.25
Age at assessment (mean; median)	40.60***; 41***	36.77; 36
White ethnicity (%)	86.74**	91.23
LSOA's income deprivation		
Decile 1 (%)	10.37	10.53
Decile 2 (%)	10.55***	22.37
Decile 3 (%)	10.79***	16.67
Decile 4 (%)	11.10***	19.30
Decile 5 (%)	11.32	12.72
Decile 6 (%)	11.40	9.65
Decile 7 (%)	11.38***	3.07
Decile 8 (%)	11.61***	4.82
Decile 9 (%)	11.48***	0.88
Rank (mean; median)	15,083.96***; 15,247***	10,582.49; 9,891
Sample size	764,914	228

Compliance with self-isolation

Table 4.3 illustrates the outcome of interest; that is, the rate of compliance with self-isolation requirements (as measured by the proportion who answered the Test and Trace call 10 days after starting a self-isolation period and reported self-isolation compliance) observed among treated and untreated individuals (unmatched sample).

A higher compliance rate is observed among treated individuals (90.35%) than untreated individuals (83.67%). The difference between the compliance rates of the 2 groups (6.68 percentage points) is statistically significant at the 1% level.⁶ This figure may indicate a positive impact from Rosmini's support. However, as explained in Chapter 5, it may as well be the result of selection bias.

Table 4.3 Compliance with self-isolation requirements for the unmatched samples

	Untreated (unmatched)	Treated (unmatched)
Successfully answered day-10 Test and Trace call (%)	83.67***	90.35
Sample size	764,914	228

⁶ The difference between the 2 proportions can equally be tested by means of a simple regression which uses the binary outcome variable (coded as 1 if the individual complied and 0 otherwise) as the dependent variable and a binary treatment indicator (coded as 1 if the individual resided in a treated LAD and 0 otherwise) as the only explanatory variable.

Impact evaluation: results

Empirical methodology

An individual's treatment status (whether they lived in a LAD where the pilot was rolled out or not, or whether they were supported by Rosmini or not) was not the result of a random assignment, and therefore the pre-treatment covariates considered here are expected to differ between treated and control individuals. Indeed, as shown in Chapter 4, the treated and untreated groups were significantly different on several explored characteristics.

Therefore, the higher compliance rate observed among treated compared to untreated individuals may, all or in part, be attributable to these differences between the 2 groups (selection bias) rather than being the direct result of the support provided by Rosmini. For example, if women were less likely than men to comply with self-isolation requirements, then gender differences (a higher proportion of men among the treated) could be responsible for the observed positive difference between the compliance rates of the 2 groups. In this example, calculating the effect of Rosmini's support as the simple difference between the proportions complying in the treated and untreated group would over-estimate the real impact.

Coarsened Exact Matching (CEM) was undertaken to identify, among all untreated individuals, the subset who are most similar to treated individuals across the characteristics of gender, ethnicity, age and income deprivation. Essentially, a treated individual was matched (paired) to one or more untreated people with similar characteristics, and in this way a matched, untreated subset was identified. The impact of Rosmini's support could then be calculated as the difference between the compliance rates observed among the treated and the 'matched' subset of untreated people.

The rationale behind this approach is that the similarity between the treated and the untreated group imposed by the matching process mimics the result of a random experiment (random assignment of treatment) and therefore any difference in the outcome of interest can solely be attributed to Rosmini's support.

CEM is a matching method developed by Iacus, King and Porro (2008). It works through temporarily coarsening certain variables into substantively meaningful groups, exact matching on those coarsened data, and then retaining only the original (uncoarsened) values of the variables to implement the regression analysis used to estimate impacts on the sample of matched individuals. The variables used to implement CEM consisted of:

Female

A binary indicator of whether an individual was female or not. This was used in its original (uncoarsened) form as no further coarsening was possible.

White ethnicity

A binary indicator of whether an individual was of white ethnicity. This was used in its original (uncoarsened) form as no further coarsening was possible.

Income deprivation rank

A discrete variable indicating the income deprivation rank of the LSOA in which an individual resided. In its uncoarsened form, this variable could take 29,422 possible values (where 1 denotes the highest deprivation level, 2 the second highest level and so on).

Age

A discrete variable indicating the individual's age at the time of assessment (or pseudo assessment for untreated individuals). In its uncoarsened form, this variable could take 50 possible values (an individual's age ranges from 18 to 67).

We tested 6 different coarsening specifications. Table 5.1 reports the levels of imbalance, as represented by the multivariate L1 distance measure, associated with each different coarsening choice.⁷ L1 can range from 0 (no imbalance at all) to 1 (maximum imbalance). Using uncoarsened age and income deprivation rank variables to implement CEM (the first specification) results in an extremely high imbalance (L1=0.979) while the imbalance dramatically reduces when using fewer levels for income deprivation rank (see the values of L1 associated with specifications 5 and 6).

In specifications 2 to 4, we tried coarsening the age variable and/or the income deprivation rank variable into 18 levels each. However, the imbalance was high for these specifications.

Therefore, we ultimately decided not to coarsen the age variable into a lower number of levels, and income deprivation rank was grouped into 9 levels, namely the first 9 of the 10 deciles into which the entire LSOA population has been divided into by the ONS (no treated individual resided in decile 10, hence only 9 deciles feature in the analysis).

The preferred coarsening choice (specification 6) was the one which best balanced (that is, rendered most similar) the treated and untreated groups as the L1 associated with it is very close to (and is therefore approximated by) zero. This means that this choice balanced the treated and untreated group extremely well. For this reason, this was our preferred specification and we used it to implement CEM.

⁷ For a technical explanation of L1 see page 30 of [Blackwell, Iacus, King and Porro \(2009\)](#).

Table 5.1. Imbalance resulting from different coarsening choices

Variables used for CEM	CEM specification					
	1	2	3	4	5	6
Female (binary indicator)	x	x	x	x	x	x
Age at assessment (uncoarsened)	x			x		x
Age at assessment (18 levels)		x	x		x	
White ethnicity (binary indicator)	x	x	x	x	x	x
LSOA's income deprivation						
Decile 1					x	x
Decile 2					x	x
Decile 3					x	x
Decile 4					x	x
Decile 5					x	x
Decile 6					x	x
Decile 7					x	x
Decile 8					x	x
Decile 9					x	x
Rank (uncoarsened)	x	x				
Rank (18 levels)			x	x		
Multivariate L1 distance	0.979	0.979	0.842	0.616	0.419	0.000

Table 5.2 details the balance achieved by means of CEM (specification 6) by reporting different measures of imbalance in covariates between treatment and untreated groups (univariate L1 distance, and difference in mean and empirical quantiles). The results suggests that no imbalance is detected for any variable across the various measures.

Table 5.2 Univariate imbalance measures for the preferred coarsening choice

Variables used for CEM	L1	mean	min	25%	50%	75%	max
Female (binary indicator)	0.0	0.0	0	0	0	0	0
Age at assessment (uncoarsened)	0.0	0.0	0	0	0	0	0
White ethnicity (binary indicator)	0.0	0.0	0	0	0	0	0

Variables used for CEM	L1	mean	min	25%	50%	75%	max
LSOA's income deprivation							
Decile 1	0.0	0.0	0	0	0	0	0
Decile 2	0.0	0.0	0	0	0	0	0
Decile 3	0.0	0.0	0	0	0	0	0
Decile 4	0.0	0.0	0	0	0	0	0
Decile 5	0.0	0.0	0	0	0	0	0
Decile 6	0.0	0.0	0	0	0	0	0
Decile 7	0.0	0.0	0	0	0	0	0
Decile 8	0.0	0.0	0	0	0	0	0
Decile 9	0.0	0.0	0	0	0	0	0

Of the 764,914 untreated individuals available for analysis, 764,686 were used for CEM. The chosen matching specification defined 1,800 strata (a stratum identifies individuals with a specific combination of characteristics, for example, males of non-white ethnicity aged between 64.55 and 67, and living in a LSOA within income deprivation decile 7).

Of these 1,800 strata, 196 were 'matched', meaning that within each of them we observed at least one treated and at least one untreated individual. The 196 matched strata included 139,099 untreated individuals, which were found to be similar to the 228 treated individuals across 149 possible combinations of characteristics (that is, within each stratum, treated and untreated individuals had the same exact characteristics, as defined by the values of the variables reported in specification 6). This means that 625,587 untreated individuals were not matched.

As shown in Table 5.3, implementing CEM (specification 6) resulted in a smaller sample of 139,327 individuals, including all 228 treated people and 139,099 (of the 764,914 initially available) untreated people. This means that less than one fifth (18.2%) of untreated individuals were matched to the treated group through CEM. Following matching, the proportion of the sample that was treated increased from 0.03% to 0.16%.

Table 5.3 Size of the matched sample

Treatment group	Sample size
Untreated	139,099
Treated	228
Total	139,327

Impact on compliance

Having identified a matched subset of untreated individuals by means of CEM, the impact of Rosmini's support could now be estimated as the simple difference between the proportions who complied with self-isolation requirements among treated and (matched) untreated individuals. The Stata command `cem` (used to implement CEM) generates weights, representing the weight of the stratum for each observation. Strata with unmatched units were given a weight of 0, and treated observations were given a weight of 1. These weights were used to produce the 2 proportions.

As shown in Table 5.4, the proportion who complied among the (matched) untreated group is estimated to be 81.24%, while the proportion observed among the treated group is still 90.35% (because all treated units were used in the matching process). As a consequence, the estimated impact is 9.11ppts. This impact is around 2.4ppts higher than the impact found using the entire (unmatched) untreated group (6.68ppts).

This suggests that, in the presence of selection bias (that is, if people were more likely to be supported or sought support because of their gender, ethnicity, age and income deprivation level, and if these characteristics are correlated with the likelihood of complying with self-isolation requirements) the impact of Rosmini's support on day-10 compliance is underestimated using unmatched data.

A weighted regression of the outcome variable (denoting whether the individual complied or not) against the treatment status (coded 1 if the individual was supported by Rosmini and 0 otherwise) indicated that this impact is statistically significant at the 1% level.

Table 5.4. Impact estimates (matched sample)

	Untreated (matched)	Treated (matched)
Successfully answered day-10 Test and Trace call (%)	81.24***	90.35
Sample size	139,099	228

As suggested by Blackwell, Iacus, King and Porro (2009), when variables are coarsened, some imbalance remains in the matched data and one can attempt to remove this remaining imbalance by means of regression adjustment, adding uncoarsened variables as explanatory variables in the impact regression. Re-running the impact regression with the addition of the 4 variables capturing individual's characteristics (whether the individual is of female gender and white ethnicity, and their age at assessment date and the income deprivation rank of the LSOA in which they live) did not change the results in any substantive way. The impact estimate remained at 9.11ppts and significant at the 1% level.

As the impact evaluation used 228 of the 717 people supported by Rosmini. One may wonder whether the impact estimate is applicable to the whole treated group. Unfortunately, due to data confidentiality reasons, it was not possible to link CTAS data back to the 717 treated people observed in the MI (which contained detailed information on individuals). However, we ran a simple probit regression to explore whether the 228 people used for analysis differed from the 'unused' sample in terms of ethnicity, age and gender (the characteristics used to match CTAS data to treated people). No statistically significant differences were found in terms of these variables. This provides some reassurance that the sample used for impact evaluation is representative of the entire treated sample.

Conclusions

The provision of the flexible third sector support increased compliance with self-isolation. The impact analysis conducted to explore whether Rosmini's support improved compliance with self-isolation requirements found that the proportion who answered day-10 Test and Trace call (that is, complied) increased as a direct result of the support. The compliance rate observed among supported people was estimated to be 9.11ppts higher than it would have been had the same people not been supported.

There is no evidence that the third sector support contributed to the ancillary objective of increasing testing rates, because of how the support interacted with testing in practice (people were often alerted to the support after testing positive) and this outcome could not be evaluated. Factors that may have contributed to the positive impact on compliance include:

1. The proactive nature of the support: Not relying just on wider communications or intermediaries to make individuals aware of the support available but making the (repeated) effort to directly contact potentially eligible individuals led to over 700 people receiving support from June to December 2021.
2. The flexible nature of the support: The support took a wide variety of forms tailored to the needs of each individual (facilitating applications, administrative support, language support, emergency finance), enabling a cross-section of individual barriers to self-isolation to be tackled.

The pilot was most effective where it was able to make use of existing resources or networks and respond flexibly to a rapidly changing context

The pilot aspects that were easier to roll out were those where there was dedicated resource (such as the Rosmini model) that could hit the ground running. Attempting to mobilise parts of the system that lacked dedicated capacity to engage (housing, environmental health and so on) was more difficult.

The system-wide aspect of the pilot that appeared to gain traction was the connection between local data or intelligence, business networks and support capacity. The ability to track local data on workplace cases allowed the pilot to identify and target sectors where the need was greatest. It could then link to existing networks to target those industries (where possible) and provide a range of awareness raising or signposting materials to employers and an underpinning support service for individuals.

The pilot benefited from flexibility in delivery. The initial target audience and industries was, in effect, outdated by the time the pilot began delivery. This reflected the dynamic nature of a pandemic. One of the strengths of the pilot was the ability to adapt both the referral model and the target population focus to reflect what was needed at the time.

Overall, the pilot tried to do too much in too short a space of time, leading inevitably to a mixed picture of delivery

The pilot was too ambitious and too complex to achieve the majority of its stated objectives. Some of those objectives were too far-reaching. There were too many enabling actions required to underpin the proposed system-wide approach to properly test some of the pilot's hypotheses. Some of the assumptions underpinning the plan did not withstand much scrutiny. (For example the idea that enforcement was inhibited by a lack of capacity that could be solved through extra resource, therein unlocking additional engagement with employers, agencies and gangmasters). It is difficult to see how the safe transport idea could ever really be viable outside of a very specific set of conditions.

It also proved to be too ambitious to roll the pilot out over 3 local authority areas that covered multiple counties and where there were not necessarily mature existing working arrangements. Any perceived benefits in terms of the reach of the pilot were probably outweighed by the effort and resource required to both deliver pilot activities and set up relationships across the local authorities. This kind of capacity building activity would always take time, as it did in terms of developing employer relationships.

Annexes

Summary of planned pilot interventions

Taken from pilot bid document and with main delivery activity in practice in bold:

Financial security: increasing uptake of the £500 Support for self-isolation payments via a trusted third sector organisations (about 35% of pilot resourcing). Key activities:

- third sector organisation administering national and local discretionary scheme payments
- topping up local Test and Trace grants and providing financial incentives to workers or employers for testing
- deploying targeted lateral flow testing to workplaces and agency pick up points

Providing assurance of job security through additional resource for GLAA officers (about 5% of pilot resourcing). Key activities:

- ensuring targeted employers who use agency labour are working with licensed providers or gangmasters, and that workers who test positive do not move to a different employer
- working with labour providers or gangmasters to ensure contract security for workers

Providing COVID-19-safe transport for low paid worker (about 20% of pilot resourcing). Key activities:

- all-day bus service running across the 3 areas to accommodate different shift times and safe travel
- marshals to travel on buses and to control queues at boarding points

Financial: rent payments for people not eligible for Test and Trace and local discretion payments (about 21% of pilot resourcing). Key activities:

- assessment and payment of rents to property organisations through the third sector organisation commissioned to administer support payments
- GLAA and housing officers undertaking spot checks to ensure agency compliance with licensing standard, as well as using the lateral flow home testing scheme to encourage agencies to test workers regularly, especially new or seasonal workers

Providing COVID-19-safe accommodation for those self-isolating in shared accommodation (about 6% of pilot resourcing).

- additional GLAA and housing officer time to identify cases living in houses in multiple occupation (HMO) and undertake spot checks to assess barriers and levels of adherence to self-isolation
- referral for rent relief or alternative accommodation to enable self-isolation

The pilot is also supporting system-wide enabling activities, including: communications; worker buddies; community champions; and a whistleblowing arbitration process (about 2% of pilot resourcing collectively). It also includes resource for additional enforcement costs when required, through environmental health officers and the Health and Safety Executive, as well as overall programme management and support costs across all organisations (about 12% of pilot resourcing).

Original pilot summary evaluation framework

Source: Fenland, Peterborough and South Holland Enduring Transmission Pilot Evaluation 2021 (14 April 2021)

	Hypothesis	Inputs	Output Metrics	Outcomes
1	Providing acceptable access to the Test and Trace £500 support for self-isolation payments through a trusted third sector organisation will increase testing rates and adherence to self-isolation.	Trusted third sector organisation commissioned to administer local scheme for distributing £500 means tested and local discretionary grants. System actively promoted to and by employers along with relevant community groups.	Number of grants distributed benchmarked against existing distribution numbers. Local testing numbers at workplaces and static sites. National self-isolating data set.	Increased testing. Increased numbers of cases and contacts self-isolating.
2	Assurance of job security will increase testing and self-isolation behaviours	Engage, Educate, Encourage and Enforce Use existing GLAA powers to Ensure that employers who use agency labour contract with providers who are licensed. Ensure that workers who are positive do not move to a different employer. Ensure that employers use licensed gang masters Work with agencies or gang masters to secure contract security for workers.	Change in employer behaviours Increase in number of employers contracting with licensed providers and using licensed gang masters. Employer information regarding workers returning from self-isolation. Increase in agency worker contracts that provide job security if self-isolating Local testing and national data set information.	Increase in testing. Increase in self-isolation rates.

	Hypothesis	Inputs	Output Metrics	Outcomes
3	The provision of COVID-19 safe transport for low paid workers will increase COVID-19 safe behaviours.	<p>3.1 Establishment a network of COVID-19 safe public transport links across Peterborough, Fenland and South Holland for the transportation of agency workers and those living in rural areas to workplaces. This would be for travel to and from work but also to support employers needing to send workers home after they have had work-site positive COVID-19 test.</p> <p>3.2 All day bus service running across the 3 areas to accommodate different shift times and safe travel.</p> <p>3.3 Marshals to travel on buses and to control queues at boarding point.</p> <p>3.4 Police checks on private hire and cars on commuter routes.</p>	<p>3.1 Uptake of free transport system.</p> <p>3.2 Number of workers using cars.</p> <p>3.3 Number of workers using buses</p>	Decrease in number of contacts becoming cases.
4	Paying rent will influence testing uptake and adherence to self-isolation behaviours.			
4a	Engage, Educate, Encourage and Enforce to influence behaviours	<p>4a.1 Spot checks by GLAA and local housing teams to ensure compliance with GLAA licensing standards.</p> <p>4a.2 Utilise the lateral flow home testing scheme to encourage agencies to test their workers regularly including:</p> <ul style="list-style-type: none"> • new workers or seasonal workers • any temporary workers brought in to cover workers who are self-isolating 	<p>4a.1 GLAA compliance data.</p> <p>4a.2 Testing for new seasonal or temporary workers.</p> <p>4a.3 Local testing and national data set information.</p>	<p>Increase in testing.</p> <p>Increase in self-isolation rates.</p>

	Hypothesis	Inputs	Output Metrics	Outcomes
		4a.3 Promote the local static site for lateral flow testing		
4b	Incentivise to influence behaviour change	4b.1 GLAA request agencies and gang masters to inform (as do other employers) Public Health of any new cases including contact details. 4b.2 Cases and contacts traced by wider contact tracing team and local relevant officers. 4b.3 Rent payment agreed with property owner and accessed through third sector organisation. 4b.4 Other support provided through support for self-isolation team along with regular support calls during the self-isolation period.	4b.1 Agencies and gang master case reporting. 4b.2 Contact tracing cases closed. 4b.3 Rent payments made. 4b.4 Demand for support from the support for self-isolation team. 4b.5 Local testing and national data set information.	Increase in testing. Increase in self-isolation rates.
4c	Incentivising low paid or zero hours non-agency workforce will influence employer, property owner and worker behaviours.	4c.1 Employers inform Public Health of new cases. 4c.2 Identify those on SSP or no recourse to public funds for follow up by contact tracing and relevant officers. 4c.3 Arrange rent payment as above and other support (food deliveries).	4c.1 Employer case reporting. 4c.2 Contact tracing data for those on SSP or with no recourse to public funds. 4c.3 Rent payment and other support demand. 4c.4 Local testing and national data set information.	Increase in testing. Increase in self-isolation rates.
5	The provision of COVID-19 safe accommodation will influence the	GLAA spot-checks to assess barriers and level of adherence to self-isolation. (includes non-licensed) Whole household isolating No facilities to self-isolate.	5.1 GLAA data on spot checks and level of adherence. 5.2 Numbers referred to third sector organisation for rent and other forms of support.	Increase in testing. Increase in self-isolation.

	Hypothesis	Inputs	Output Metrics	Outcomes
	behaviour of workers who are cases.	Cases and contacts identified and referred for rent relief and other support for self-isolation. If no other options for self-isolation available, provide local temporary housing accommodation.	5.3 Numbers provided with temporary accommodation for self-isolation. Local testing and national data set information.	
6.	Enablers			
6a	Agencies, employers and communities own and champion this programme, which will influence worker and employer behaviours.	6.1.1 Shared consistent communications to their workers, which involves acting as the 'good listening employer' to understand the drivers for behavioural change. (Across Labour Users and Providers, agencies and local organisations.) 6.1.2 Labour Users/Employer networks to establish and work with local authorities and other agencies to establish shared accommodation schemes for worker and family self-isolation, onsite testing, mental health support and so on. 6.1.3 Work-site onsite testing and vaccination centres with shared testing sites for smaller employers.	6a.1 Quantity and quality of communications. 6a.2 Active employer or agency networks. 6a.3 On-site testing and vaccination locations. 6a.4 Local testing and national data set information.	Increase in testing. Increase in self-isolation. Increase in vaccination.
6b	Worker incentives for supporting and championing workplaces to be COVID-19 safe influences worker behaviours	6.2.1 'Rewards' for workers offering 'buddy support' to self-isolating colleagues. 6.2.2 Worker financial incentives for having regular LFTs and vaccination.	6b.1 Employer data for 'buddy' numbers 6b.2 Financial incentive data from employers 6b.3 Local testing and national data set information.	Increase in testing Increase in self-isolation Increase in vaccination

	Hypothesis	Inputs	Output Metrics	Outcomes
6c	Worker community champions providing information on COVID-19 and how to secure support for self-isolation influences employee behaviours	6.3.1 Community champions who represent workers co-produce and promote the safe COVID-19' and the support that is available. 6.3.2 Involves 'trusted' local third sector organisation to support community champions.	6c.1 Third ^d sector organisation data on the number and activities of the community champions 6c.2 Local testing and national data set information.	Increase in testing Increase in self-isolation Increase in vaccination
6d	Engage, explain, encourage and enforce interventions influences employer and worker behaviour	6.4.1 Employees have a 'safe' route for raising their concerns. 6.5.2 Establish a model for arbitration of any 'whistleblowing' concerns. Involve trusted external organisation	6d.1 Employer information on concerns raised 6d.2 Reports to trusted organisation re concerns or whistleblowing 6d.3 Local testing and national data set information.	Increase in testing Increase in self-isolation Increase in vaccination

Qualitative research interviews

a. Delivery partners or stakeholders

	Delivery partners or stakeholders	Date
1	Anita Grodkiewicz: Rosmini	23/06/21
2	Tom Walczak: Pilot team, local authority employer engagement and cross-county work	13/08/21
3	Nikitta Vanterpool: Community Hub for Cambridgeshire and Peterborough	16/08/21
4	Mark Tunstall: Benefits Team Leader, Peterborough Serco Strategic Partnership	20/08/21
5	Jo Evans: Private Sector Housing Officer, Fenland District Council	24/08/21
6	Jane Hunt: Project Lead, Housing and Transport, Enduring COVID-19 Transmission Pilot	19/08/21
7	Cath Mitchell: LFT Testing Lead, Enduring Transmission Pilot	23/08/21
8	Annabel Tighe – Business Change Manager Fenland local authority	3/9/21
9	Donna Hall – Business Change Manager South Holland local authority	9/9/21
10	Rosmini frontline staff: Anita Grodkiewicz Mikelis Zemdega Mark Griffin Simona Cismasu	10/9/21

b. Employer

	Employer	Date
1	Smart Garden Products Ltd – Jakki Avery (Operations Development Manager)	18/08/21
2	Suncrop Produce Ltd – Tim Hobbins (Operations)	10/09/21
3	Purina Nestle - Nigel McConachie (SHE Manager)	19/08/21
4	Amazon – Gareth Davies	12/08/21
5	Greencore – Julie Routledge (Head of Occupational Health)	08/09/21
6	Dalehead Foods – Beth Baker (HR Advisor)	08/09/21

Assignment of pseudo-assessment dates to untreated individuals

To generate the pseudo-assessment dates, the steps outlined by Ainsworth and Marlow (2011)⁸ were followed:

Step 1

All treated people (those supported by Rosmini) who could be matched to CTAS data were separated according to the week they tested positive for COVID-19. In this way, 28 separate data sets were created: one for those who tested positive between 14 June and 20 June 2021 (tested in the first week), one for those who tested positive between 21 June and 27 June 2021 (tested in the second week), and so on up to the latest assessment week included in the analysis, which is the week 20 to 26 Dec 2021 (tested in the 28th week).

Step 2

For each of the 28 data sets obtained at Step 1 (that is, for each week in which treated people tested positive for COVID-19), we calculated the proportion assessed by Rosmini in each possible week. For example, for all participants who tested positive in week 16, we observed people who were assessed in 3 different weeks, namely weeks 16, 17 and 18 (see Table A4.1).

Table A4.1 Illustrative example: proportion of treated individuals who tested positive for COVID-19 in week 16 who were assessed by Rosmini in each week

Week tested	% Assessed							Cumulative %
	W1	...	W16	W17	W18	...	W28	
W16 (19 to 25 July 2021)	-	-	14.29	78.57	7.14	-	-	100

Step 3

All untreated individuals were separated according to the week they tested positive for COVID-19, in the same manner as we did for treated individuals. In this way, 28 other data sets were created.

Step 4

Within each of the data sets obtained at Step 3, we randomly assigned an assessment date to each untreated person in such a way as to mirror the distribution of assessment weeks observed in the corresponding treated data set. For example, 14.29% of the untreated people who tested positive for COVID-19 between the 19 and 25 July 2021 were assigned a random

⁸ Ainsworth and Marlow (2011). [‘Early Impacts of the European Social Fund 2007 to 2013’](#) pages 54 to 55.

assessment date within week 16, 78.57% were assigned a random assessment date within week 17, and 7.14% were assigned a random assessment date within week 18.

Step 5

In assigning pseudo-assessment dates to untreated individuals, a uniform distribution was used. This means that the days of the week assigned were equally likely.

Step 6

If an assigned pseudo assessment date occurred before the date the untreated individual tested positive for COVID-19, then this pseudo-assessment date was considered invalid and the record was removed from the sample.

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