UK Health Security Agency

City of London and Hackney: assessment and evaluation of the enhanced self-isolation pilot (ESIP) project

May to November 2021

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Executive summary

The Department of Health and Social Care (DHSC) funded a pilot in the City of London and Hackney to test innovative ways to support people to self-isolate in order to reduce household level transmission of COVID-19.

An offer of support was developed that was accessible through multiple pathways, which we refer to as the enhanced self isolation pilot (ESIP). A key element trialled during the pilot was external accommodation for self-isolation. Other elements included care packages, welfare calls, food support and grant support.

The project hinged on partnership working but the service delivery was managed through the project lead who acted as the referral hub.

User feedback on support received was generally positive but numbers supported were too small to evidence an effect on household transmission. As such, the pilot can be seen to have been beneficial to individuals but without effect at the population level.

Learning from the project has led to the following recommendations:

1. A simple and easy-to-manage system of providing care packages promptly works well, and local authorities could be funded to do this during periods of lockdown or when isolation is required.
2. Accommodation provision does not work well at the borough level. If this is to be sustainable, it would need to be at a bigger geographic footprint, for example, London-wide.
3. Any programs for isolation support need a generous amount of time to be designed and implemented, as the leads will need good relationships with a wide variety of stakeholders. These take time to establish.
4. Although some of the interventions are quite low cost, they require dedicated staff time to oversee. This needs allocated funding and would otherwise be difficult to integrate with local authority business as usual.

Section A. Background and conceptualisation

1. Introduction

Funding was provided by the DHSC to develop and implement the enhanced self-isolation pilot (ESIP) project, based on the expression of interest (EOI) submitted in March 2021.

The project intended to test innovative ways to encourage and support people to self-isolate fully and successfully in order to reduce household level transmission of COVID-19. To do so it would make use of existing services and pathways and develop new interventions and a referral hub where people would be triaged for support. The pilot was targeted towards 2 social housing estates in Hackney and several housing estates in the City of London. Criteria for this were related to high infection levels at local level (Woodberry Down) and higher than average Black and ethnically diverse population numbers (Pembury).

EOI summary of project intention

Improve health protection by providing a rapid, time limited, enhance self-isolation package to mitigate risks associated with high density housing and personal circumstances. We will identify sources transmission earlier and prevent onward household transmission through integrated services and investment in co-design to ensure people feel able to take up this offer.

Both Woodberry Down and Pembury estates are supported by robust networks of council officers, tenants associations and housing association staff, supporting communications, engagement and referrals at the point of most need.

Our model is informed by learning from contact tracing and includes a referral hub where people are triaged for support. We will use behaviour insights, community champions and the housing community partnership network to ensure we are people focused. Our intention is to provide a more holistic service, from enhanced local contact tracing and housing insights. During triage we will contact to important pathways of support. This includes access to food, welfare, infection prevention control (IPC) assessment, advice and provision, access to wider testing and grants.

The EOI suggested that the pilot would sit within the newly formed Outbreak Identification and Rapid Response (OIRR) service that was developed by the City and Hackney Public Health team.

It was also envisaged as a joint pilot between Hackney's Housing and Benefits Team, City and Hackney Public Health Team and the City of London's Community and Children's Department. This way, it would support existing partnership work through the sharing of data sets and work on more complex issues associated with self-isolation support, via housing officers (HOs) and the welfare support service of Hackney's 'Here to Help' programme.

The key groups ESIP intended to reach and support were split-care families; those living with long-term conditions or the clinically extremely vulnerable and those experiencing financial hardship.

EOI intended achievements

This enhanced self-isolation offer aims to achieve:

- the prevention of onward household transmission in a population which research tells us experience barriers and challenges to self-isolation
- provide an enhanced, co-produced health protection response which can be evidenced as having a wider application locally
- through co-production and nimble trials, refine and develop the range of interventions which support self-isolation
- follow-up with households once the self-isolation period is over to capture any lessons learnt and integrate this learning as the pilot develops
- arrive at a refined range of interventions which are sustainably resourced and can be offered wider if and when required. Look to disseminate this learning within communities to create accepted and practiced social norms

Presently the range of interventions includes:

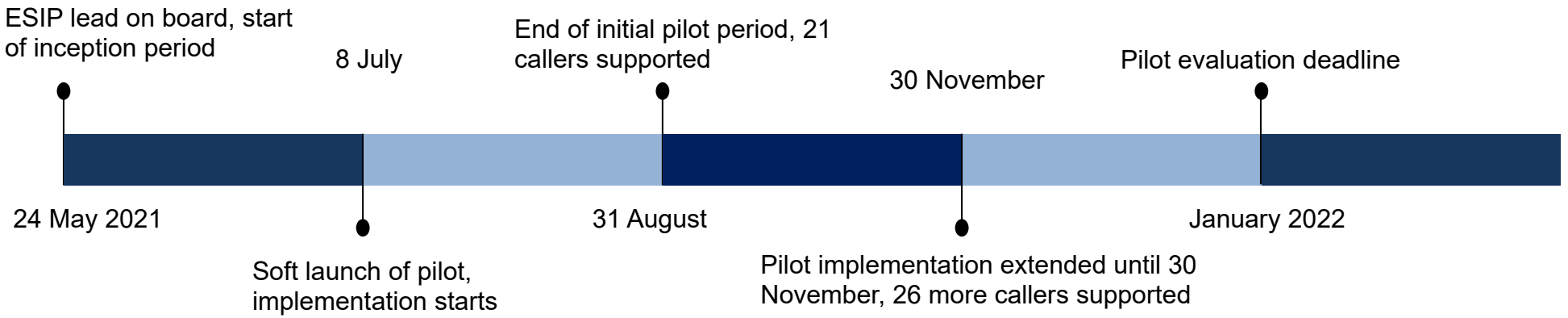
- rapid, tailored IPC advice
- accessible and tailored ‘how to self-isolate guides’ co-produced and informed by behavioural insights for different groups, for example: the clinically extremely vulnerable, frontline workers, single parent households, student and migrant renters, multigenerational households
- additional supplies of personal protective equipment (PPE)
- the offer to accommodate household members outside of the home for 10 days
- rapid referrals for emergency food provision and financial assistance and onward referral for longer term local support

To ensure that throughout this pilot and in the absence of concrete evidence on household transmission of COVID-19, it is very important to proceed in ways that do not reinforce stigma and stereotypes of various types of ‘risky’ communities.

This pilot includes our enhanced local contact tracing service which has recently received commendation from the DHSC as one of the best performing boroughs in London.

A project lead was recruited who started work on Monday 24 May. At this point, it was understood the pilot would have a short lead period, start implementing in July until the end of August, and then be evaluated during September to October. It was subsequently extended until the end of November 2021.

Project timeline



Text version of project timeline

24 May: ESIP lead on board, start of inception period.
8 July: soft launch of pilot, implementation starts.
31 August: end of initial pilot period, 21 callers supported.
30 November: Pilot implementation extended until 30 November, 26 more callers supported.
January 2022: Pilot evaluation deadline.

End of text version of project timeline

The project lead worked closely with the change support team and received guidance and oversight from a principal public health specialist and a public health consultant. The core team consisted of:

- ESIP lead (project manager) (senior public health practitioner)
- principal public health specialist and consultant (oversight)
- behavioural insights analyst (Change Support Team)
- service designer (Change Support Team)
- data analyst (Change Support Team)

The total budget for the pilot was £81,314.30, of which £54,000 was set aside for external accommodation.

2. Lead period preparation, conceptualisation and engagement

2.1 Inception

The start of the project meant getting a joint understanding of the intention of the pilot, exploring which elements of support to develop and include, and assessing which stakeholders (internal and external) to engage with.

Internally, the core team held regular meetings to develop this and to plan how to engage with residents for codesign of certain interventions. Initial discussions were guided by behavioural research and insights into attitudes and barriers to self-isolation.

Throughout the inception and initial implementation phase, the service designer and the ESIP lead would have regular 'retrospectives' to assess progress and to pick up on any challenges. The project lead further had regular check-ins with the principal public health specialist and the public health consultant for oversight and to link with wider COVID-19 related work.

The project lead developed a work and implementation plan to structure the process and to assess when deliverables should be ready. This plan also served as an initial basis for the weekly updates with the team at DHSC/PHE (later UKSHA) that started in early June 2021.

The project lead further planned meetings with different stakeholders, in particular Housing colleagues, as they were the gateway to engage with residents at the Woodberry Down pilot site. Communication was also initiated with housing staff at Pembury Estate (the other Hackney pilot site), which is owned and managed by the Peabody Housing Association.

Internally, the lead initiated engagement with the COVID-19 Here to Help helpline manager, the manager of the local contact tracing team (LCT), the communications team and the design team. The project lead also attended briefings on the emergency food referral system and the community champions programme.

Engagement with colleagues at the City of London was limited in the lead period due to staff changes.

A list of stakeholders and their role in or relationship to the pilot is presented in Annexe 2.

Learning and challenges: inception

1. Everything is unclear at the start. Accept that there is a fair amount of uncertainty.
2. The project lead was external and had no prior knowledge of teams, stakeholders and ways of working at Hackney Council.

2.2 Codesign

As set out in the EOI, developing interventions with residents was to be a core element of the pilot to ensure that what was being developed was approved and accepted by residents, in particular the targeted ‘How to' guides for self-isolation.

To facilitate communication with residents, engagement was required with housing officers and staff at the 2 Hackney pilot estates.

The ESIP lead and the service designer made a site visit to Woodberry Down on 10 June to engage with designated housing officers and voluntary and community sector (VCS) representatives (Woodberry Aid) to learn more about the estate, the residents, demographics and the impact of COVID-19. This was a useful and important start to engagement.

One practical outcome of the meeting with Woodberry Aid was their suggestion to have a testing pop-up before the launch of the pilot, to encourage people to test and to raise awareness about the pilot. As a result, a testing pop-up was done at both sites at the start of the pilot and repeated some weeks later. This was a spontaneous rather than deliberate example of codesign and illustrates the importance of being receptive and responsive. Further input was provided (by Woodberry Aid as well as the housing officers) on subjects and target audiences for ‘how to’ self-isolation guides, barriers to self-isolation (lack of money), and main other languages spoken at the estate.

Subsequently, communication was sent out to Woodberry Down residents via email and text to invite them to participate in focus group discussions. This was done with the assistance of the housing area manager.

Residents were invited to participate in 2 rounds of focus group discussions (FGD). The first round was to gain residents’ experiences and insights into motivation and ability around self-isolation and awareness of existing support.

The second round was to present and discuss the ‘How to’ guides for self-isolation to discuss topics, language, imagery and overall design for relevance and appeal. The feedback from various sessions led to significant changes in topics, language and design.

Regular communication with Pembury estate staff was harder to establish as this was an external partner. Similar messages and invitations were shared and resulted in some representation by Pembury residents in the FGD.

Learning and challenges: codesign

1. Engagement takes time. Recruiting residents and setting up focus group discussions is a process that takes weeks, not days.
2. Codesign requires curiosity, listening and openness as well as follow-through on practical suggestions.

3. Codesign as a concept is valuable to ensure what is being designed is more acceptable and accessible to residents. However, within the scope and timescale of the pilot, the codesign was effectively limited to the 'How to' guides.

2.3 Consolidating the offer of support

In June, the discussion centred on what should or could be included in the overall offer of self-isolation support. The EOI had already indicated that the support offer would be a combination of existing support (emergency food referrals, isolation grant advice) and new interventions.

One specific new trial intervention was the offer of external accommodation. The rationale for this was that by taking a positive case out of, for example, a house-share, or a multi-generational family with limited space, the case could be helped to self-isolate without putting the close contacts in the house at risk and hence reduce the chance of transmission. Equally, if a close contact was perhaps clinically vulnerable, they could be self-isolating externally while the positive case remained in the home. The thinking was always to be flexible in approach as to whom external accommodation would be most suitable for.

What proved to be a continuous and time consuming challenge was finding a supplier that was willing to accept both positive cases and close contacts, as illustrated in the box below.

Securing accommodation

Securing accommodation has been a major challenge throughout the pilot, in particular for positive cases.

In mid-June a hotel was found that was willing and able to accept both close contacts and positive cases. This came after a number of cheaper and more local Hackney-based hotels had been contacted, without result. The ESIP lead also unsuccessfully pursued the option of finding a hotel through the Hackney Council central booking agent.

Less than 48 hours before the planned launch of the pilot on 1 July the hotel withdrew from the pilot as it had been requisitioned by the Government as a quarantining hotel. This led to the delay of the soft launch by one week during which time the ESIP lead engaged with other providers. An alternative hotel, suggested by the original hotel, was willing to accept close contacts but not positive cases. Therefore, the pilot soft-launched on 8 July with only provision of external accommodation for close (household) contacts. This also led to changing text in promotional materials and having to communicate the change to stakeholders.

Eventually, a supplier of self-catering apartments was found toward the end of July with the willingness and ability to provide apartments for positive cases. After more delays due to incorrect furniture being delivered to the 4 units, they became available from 3 August until the end of the pilot period, 31 August 2021. Again, this made an update in promotional communications and stakeholder engagement necessary to announce that accommodation could now be offered to positive cases. This was done predominantly through emails and a

show and tell type project update. Some press announcements about the pilot were also made, for example, by the City of London, that highlighted the accommodation option. Internal communication focused on helpline call handlers.

After the official end of the pilot, the DHSC agreed a no-cost extension for the project to run until 30 November 2021. This required a renewal of the agreement with the supplier of self-catering apartments. Facility for hotel accommodation was by now less important after the change of isolation guidance for close contacts with double vaccination status on 16 August.

The supplier did not have availability of suitably priced apartments at the start of September, but from 23 September one of the original units was booked on retainer until 30 November, meaning positive cases could be accommodated again.

In total, during the pilot period, one person isolated in the hotel as a close contact, 6 individuals were accommodated in self-catering apartments, and one COVID-positive family was offered emergency accommodation in an Airbnb.

At this point in the pandemic (mid-2021), providing a polymerase chain reaction (PCR) test to people in their homes was seen as a useful intervention: by having quick access to a PCR, a person would sooner have a confirmed positive or negative result. The potential negative PCR result would mean they could stop isolating and could be seen as an incentive.

The PCR test in combination with lateral flow tests, PPE, and the ‘how to’ guides were eventually merged into what became known as the Care Package. This became a practical token of support that could directly help people with safe isolation practices at home.

Once the pilot launched, this was the offer of support:

- care package including PCR test and lateral flow tests (LFTs), PPE, ‘how to’ guides on self-isolation (developed for the pilot), hand sanitiser (cleaning spray and thermometer were added towards the end of the implementation period)
- external accommodation (positive cases and/or close contacts, changing over time)
- infection prevention control advice
- welfare calls (already existing, but limited)
- emergency isolation food support (existing)
- support with accessing £500 grant (existing)
- incidental support (for example, referral for energy voucher, onward referrals to other resources such as NHS Volunteers or Shoreditch Trust, craft packs, toys or books for children – a combination of existing and new support)

Options such as a 10-day exercise package, access to devices, mobile data vouchers, daily diary tracking and ‘buddy support’ did not materialise as they either were too time consuming to put together, or not enough resources could be found to be able to provide them in the limited time available.

The project team frequently discussed who the support was for, how they would know about it and how they could be reached. With the focus still on the housing estates, and promotional material targeted towards these residents, the expectation was that housing officers, staff and community champions in the relevant neighbourhoods would help to identify those most in need, while promotion from the council through leaflets and targeted social media and news pieces would create general awareness.

Learning and challenges: support offer

- identifying groups that are regarded as most at risk, most unlikely or unable to self-isolate or most in need of support (based on evidence) does not mean a project is by definition designed, likely or able to reach them
- how can you be sure that what you offer is what is needed? would more codesign have addressed this? if you really want to foster codesign, should a resident or community representative have been part of the process from start to finish? this would have time and resource implications (person should be paid)
- every element of support needs time and resources to create; securing accommodation was crucial to the pilot but was time consuming due to reluctance by providers to accommodate people with COVID-19

3. Operationalisation

While deciding on the offer of support and trying to secure accommodation, another challenge was how to operationalise and implement the eventual offer of support and, effectively, how to run the pilot.

From the onset, it was clear the pilot would depend on collaboration across a wide range of stakeholders, both internal and external. The project lead was instrumental in engaging with these various parties but, having been recruited from outside Hackney Council, they had no prior knowledge and experience of internal teams and ways of working.

There was no clear or existing framework for engagement and the pilot did not sit within the Outbreak Identification and Rapid Response (OIRR) service, as thought at the conceptual phase of the EOI. It would also be fair to say the pilot was never truly a joint pilot between Hackney's Housing and Benefits Team, the City and Hackney Public Health team and the City of London's Community and Children's Department, consultation notwithstanding.

As such, it was largely up to the project lead and the service designer to devise the operational structure and the referral pathway, with oversight by the principal public health specialist. Having a central project lead pushing and pulling the pilot into shape has advantages and disadvantages. An advantage is the initiative and communication is coming from one place and is soon recognised by different partners. The lead knows exactly what is going on and what still needs to be done, and things can move quicker. The latter was necessary given the short time-frame. As the project progressed towards implementation, the lead also took on the role of

service provider. In some ways, this may have been helpful with the profile of the pilot, especially internally. The drawbacks are there may not be as much buy-in from stakeholders as a true co-pilot set up may have fostered. It is also easier to leave things to be done by the lead, and for things to remain 'stand-alone', especially with the lead becoming the service provider.

3.1 Referral pathways

As the support offer was a combination of existing and new interventions, it made sense to link with the services already offering the existing support elements, that is, the Here to Help COVID-19 helpline and the local contact tracing team (LCT). For example, helpline call handlers could take calls for support and be able to offer additional interventions, while the LCT would be key to reaching people earlier in their isolation journey to stop onward transmission at household level. However, in practice this was more challenging than anticipated due to existing workloads, the difficulty in identifying 'high support need' cases from a database, and the actual low need for support expressed by people when contacted by the LCT for contact tracing.

With the initial focus on selected housing estates, the thinking was also to work closely with the housing officers (HOs) in identifying households struggling to self-isolate as another entry point for support. This proved challenging early on as due to the pandemic, the HOs had far reduced immediate interaction with residents. Also, as the Pembury estate was managed by an external housing association, regular communication was more challenging.

Another pathway to reach residents directly was through the community champions (CC). The community champions are neighbourhood-based volunteers who provide factual information on COVID-19 and can advise people on where to go for vaccinations, for example. Community champions would be able to refer people to the pilot.

Referral guidance was prepared for housing offers and community champions, with a Google referral form that would be picked up by the ESIP lead.

As both helpline and LCT could not 'home' the pilot's implementation phase, the ESIP lead herself became the de facto referral hub and implemented the pilot by triaging the support needs and making the support offers. Incoming calls to the helpline requesting enhanced self-isolation support were referred to the ESIP lead via the manager of a static asymptomatic test site (ATS) centre, and also taken directly by the ESIP lead after closing time of the test centre. To provide weekend cover, it was agreed that the LCT weekend call team would be able to offer a limited offer of support, and a shortened script was prepared for this purpose.

With the referral pathway in place and with the ESIP lead as hub, the pilot soft-launched on 8 July 2021. The ESIP lead prepared a number of operational tools, assets and process documents to support this, including a script to assess all the support needs of the caller. These are all listed and linked in Annexe 1. Several resources were adapted or copied from work already done by other boroughs doing similar work. This saved time and effort and was an early indication of the willingness between local government colleagues to collaborate.

The various 'ways in' are captured in a user journey that was designed by the service designer. The service designer frequently made schematics and mural boards to illustrate how the user journey would be and what this would mean or require in practice.

Learning and challenges: operationalisation

1. Reality is different from what may seem ideal, or from what was originally envisaged (EOI document). Adaptability is key. This can mean that what is achieved is different from what was intended.
2. Having a service designer on the team is an asset. Visualising trajectories and pathways helps to ask questions (who does what, where, why and so on), identify operational or logistical needs and ensures the trajectory makes sense.
3. How a pilot is led or set up will affect ownership and implementation.

4 Monitoring and evaluation

As one of a series of pilot projects funded by the DHSC, the Monitoring and Evaluation (M&E) component was emphasised from the start. With the Behavioural Support Team as part of the core team, including the data analyst, an evaluation framework was developed early on, alongside the implementation plan.

Data collection took place at several moments. Firstly, during the initial assessment calls by the ESIP lead with a caller or referred case. Secondly, by collating call and user data for the Helpline, the emergency food support and the isolation grant support. This was useful to place the ESIP support in a broader context of need relating to self-isolation. Lastly, follow-up surveys gathered data provided by users relating to the support elements and how they had experienced this.

The service designer and the data analyst designed a survey to collect user feedback. The ESIP lead sent this to every person who had taken up any element of the ESIP support offer, usually as a link via a text message. A £10 Love2Shop voucher was offered as an incentive to users to complete the survey.

The Data Analyst also created a dashboard that collated feedback from completed surveys as well as the user data collected by the ESIP lead in assessment calls. The dashboard gives a visual overview of the responses and enables manipulation by date and subsets.

Having a data analyst and service designer on the team was a strength of the pilot. The evaluation element was never an afterthought, and being able to visualise the referral pathway, for example, helped in operationalising the pilot.

4.1 Criteria for indicators

A number of indicators were chosen to reflect the user journey and the experience of the services provided, as well as some immediate outcomes. Longer term outcome indicators were

included but would prove hard to evidence due to relatively low user numbers and the fact that people called in for different reasons; when someone asked about grant status, this was by definition post-infection and support provided would have no influence on, for example, onward transmission. Equally, if someone called about food support mid-way through their isolation period with 3 positive cases in the household, preventing further transmission to a fourth person was near impossible if, for example, the remaining negative adult had a caring role toward their young children with COVID-19. In that sense, the pilot became more about enabling people to fully self-isolate (for example, providing food so they would not go out to shops) than preventing onward transmission of infection.

The indicators to measure reach, output and outcomes are listed in Table 1 (below). As indicated, longer term behavioural indicators were included but there is not sufficient data to demonstrate this level of impact.

The reach indicators can be seen in the wider context of need for support with self-isolation, as well as the different elements of support within the pilot.

The output indicators give some insight into how people experienced the service and if this would warrant continuing the interventions or replicating them elsewhere.

The short-term outcome indicator is a measure of the immediate result of the interventions.

Table 1. Indicators

Reach indicators	Number offered the service Number who used the service (uptake)
Output indicators	Number of people who would use the service again Number of people who would recommend the service to others
Outcomes or short to medium-term indicators	Number of people staying for the whole 10 days
Impact or longer-term behavioural indicators	Number of cases of COVID-19 within the household where the service user is rapidly referred and supported during the isolation period

4.2 Limitations

Looking at the questions in the evaluation framework, developed at the start, and the potential for answering them at the end of the pilot, some did not have an adequate data source. Equally, due to the limited size and length of the pilot, in some cases not enough data could be gathered to provide sufficient insights, especially in terms of long-term outcomes and impact. As such, the value of the learning of the pilot may be more in the qualitative feedback than in quantitative evidence.

Learning and challenges: evaluation

1. Having a data analyst on the project team is an asset and ensures monitoring and evaluation are integrated from the start.
2. Indicators and questions that seems sensible and important at the outset may not get answered due to lack of data sources or insufficient findings.

Section B. Pilot implementation

5. Implementation

Every person who called or was referred to the pilot was spoken to by the ESIP lead. During this assessment, or support triaging call, information was gathered and subsequently collated in a Google sheet. The call established what type of support was needed, if any, and the ESIP lead would either make referrals during the call (for example, food referral or care package request) or follow-up and provide information afterwards (for example, when the caller asked about grant status). The tone and duration of the call would very much be influenced by the caller, their needs and their (emotional) state of mind. The ESIP lead had prepared a full script to guide the calls, which was less needed after time and practice.

5.1 Scope of implementation

Once the pilot soft-launched on 8 July it was almost immediately opened up to the entire Borough of Hackney and the City of London; to limit the support to residents of selected estates would exclude swathes of people from support that could help them self-isolate. Also, the demand from just a few estates would prove too low to give any useful indication of actual need. This change in scope posed a number of challenges. The messaging and awareness raising about the pilot had to be upgraded and amplified. This process took time – leaflets needed to be redesigned and reprinted – and active involvement by the Communication Team.

The role of housing officers or staff became unclear. Due to the pandemic, HOs already had much reduced contact with residents and identifying and referring households with COVID-19 in need of support was not practically feasible. Communication with Pembury Estate staff has proved quite difficult due to limited staffing and high workloads.

During the extension phase of the pilot (September to November) the ESIP lead engaged with Housing to explore the further involvement of HOs throughout the borough but this did not gain traction.

Beyond the change in geographical scope, the pilot was affected by changes in the policy environment. From 16 August 2021, self-isolation guidance for fully vaccinated close contacts changed so they would no longer have to self-isolate. Offering accommodation to close contacts therefore became less relevant while it remained challenging to find accommodation providers willing to accommodate positive cases.

Learning and challenges: scope of implementation

Changes in policy, scope or other (external) factors will affect implementation in often unforeseen ways. Original intentions may have to be adjusted. Delays may occur, even if only to update messaging and communication.

5.2 Stakeholders and collaboration

The pilot was reliant on collaboration with a range of stakeholders, both internal and external. It was encouraging that especially during the extended implementation period new connections and routes towards support were made, for example, with the hospital discharge team. Stakeholder engagement is important and takes time. Introductions need to be made, meetings need to be planned, mutual understanding and awareness on relationship, roles or responsibilities need to be fostered and shaped over time. Different stages can require different parties to be involved. Throughout the pilot it was a key task of the ESIP lead to manage and maintain stakeholder relationships.

A list of stakeholders is included in Annexe 2. This section will highlight some examples of collaboration.

5.2.1 Community champions

As a COVID-specific community-based response set up by the public health team, there was good collaboration as the work of each initiative reinforced the other. This was evidenced through:

- regular and mutual sharing of information, including promotional leaflets
- contributions by the ESIP lead to the CC newsletter
- participation of ESIP lead in CC online forums and briefing on the pilot
- attendance of ESIP project updates by representatives of the CC community
- CCs had the ability to make referrals into the pilot using the referral form
- in the extension period, CCs were able to request care packages directly

Community champions made 2 referrals to ESIP and were able to request care packages for households with COVID-19 in the extension period of the pilot. Two referrals is not many, and there is room for improvement in active participation, beyond the pilot. In terms of communication the connection with the Champions management team was strong.

5.2.2 Test and Trace food referral

Equally, as a service borne out of the pandemic, there was good collaboration with the team in Policy and Strategic Delivery that was managing the emergency self-isolation food support, in conjunction with the helpline and LCT call handlers and the community-based food consortia. Overall, collaboration was achieved through:

- sharing of information
- briefing of ESIP lead on food referral process
- participation of ESIP lead in food consortia online forum to brief on the pilot
- attendance by food referral partners and management of ESIP project updates
- in the extension period, the food consortia were all provided with sets of care packages to deliver alongside food parcels

Providing food consortia with care packages is an example of how the ESIP support has been integrated into overall self-isolation support.

Since the end of the pilot on 30 November, the management of the food referral has been transferred to Public Health and has become one of the key tasks of the ESIP lead.

5.2.3 Here to Help helpline and LCT call teams

Two sides of the same coin, collaboration with these teams and their managers was key to implementation of the pilot. As both teams faced heavy and fluctuating workloads (for example, the Helpline would one month be inundated with calls about vaccines, and another month with calls about the £500 self-isolation grant) the ESIP lead's understanding that handling of ESIP calls would best sit with either or both of the teams as the quickest pathway for ESIP support did not work out in practice. Hence the de facto designation of the ESIP lead as the referral hub for the pilot. It was agreed that the LCT weekend call team would provide cover for weekends, being able to offer food support, care packages and accommodation.

Overall collaboration took place through:

- briefing of call handlers and duty managers on ESIP, what it entailed and how they could refer people for enhanced self-isolation support
- ongoing communication with team managers
- preparing a shortened script and a supporting document for the weekend LCT call team alongside a targeted briefing
- updates for weekend call team through Google Currents, as and when relevant
- engaging with call handlers through chat to support referrals and answer queries
- providing a briefing and adapted script to cover for the ESIP lead in her absence
- inviting managers and call handlers to ESIP project updates

During the extension period, engagement took place with managers to discuss if and how ESIP support could be integrated and in December a model was found that would keep all support except external accommodation accessible, predominantly through the Helpline call agents and with ongoing support from the ESIP lead.

5.2.4 Health Protection, Testing and Logistics team

The Health Protection, Testing and Logistics team was itself a newly formed team, emerging out of Civil Protection. Collaboration with this team was excellent and crucial to the pilot's implementation:

- the manager at a static testing site received the incoming calls for ESIP support until 2pm every weekday and completed a referral for the ESIP lead
- the mobile testing team distributed promotional leaflets and provided information to passers-by about self-isolation support
- the logistics team assembled the care packages and delivered them to households, usually the same day

During the extension phase, the pilot consolidated its approach to the purchasing of toys and the logistics team became the custodians of the stock. In fact, purchasing of incidentals such as toys and thermometers (for care packages) was only possible once the team's manager had a purchase card.

Inability to make spot purchases of smaller items was not a major constraint to overall implementation but it made the pilot lack agility.

Engagement with the Health Protection, Testing and Logistics team was through:

- participation by ESIP lead in three testing pop-ups
- briefing of all testing staff (static and mobile) on ESIP support
- participation in ESIP online project updates
- contribution to Testing Times newsletter
- regular calls, emails and chat with managers and team members

5.2.5 City of London

The initial collaboration with the City of London was somewhat limited due to staff changes. This changed considerably in August when a concerted effort was made to promote the pilot in the City of London. The ESIP lead worked closely with the communications officer and the Department of Community and Children's Services.

Once launched, the pilot was open to all residents in the City. Yet even with the extension period, only one call for support was made from the City. This may indicate sufficient support was already in place and enhanced support was not needed. Equally, the City of London only counts around 8000 residents and demand would be expected to be lower.

5.2.6 Collaboration and exchange with other boroughs

Over the lifetime of the pilot there was regular exchange with and learning from other boroughs and local authorities.

The main 'partner' was Newham, itself implementing an isolation support pilot that included external accommodation. The sharing of experiences and resources, especially with Newham and Havering (agreements, standard operating procedures, promotional materials) was encouraging and helped to avoid reinventing the wheel, whilst duplicating best practice where appropriate.

To illustrate the extent of the collaboration, when the ESIP lead needed accommodation for a positive case in Hackney and had no apartment available, the person was accommodated by the Newham pilot's provider.

Once the Hackney and City of London pilot had become more established, other boroughs came with queries and the ESIP lead shared her experiences and resources.

List of boroughs and local government engaged with:

- Newham
- Havering
- Lambeth
- Bromley
- Ealing
- West Berkshire
- Cheshire East

Learning and challenges: stakeholders and collaboration

1. Collaboration took many forms and was crucial to getting the pilot implemented.
2. Engagement with partners is a continuous process and doesn't stop once implementation starts.
3. Partners can change throughout the lifecycle of the pilot.
4. Each partner has a specific role; minor logistical issues can disrupt or delay as much as high level lack of engagement.
5. Exchange with other local authorities was enriching and, where data and resources were shared, saved time and effort.

5.3 Communication and outreach

For any project to be successful, people need to know about it and feel able to access the support on offer, which was a key objective of the EOI.

5.3.1 Communications

With a very short lead time and the pilot being designed from scratch, the issue of how and where to promote the eventual support offer was always a foremost consideration though not perhaps the best executed.

Initial messaging was aimed towards residents of the selected estates (especially in Hackney) through the promotional leaflet and text messages and/or emails to be sent through the Housing team at Hackney and the Housing staff at Peabody's. Messages were also shared with the VCS Woodberry Aid and WDCO, the tenants and residents association at Woodberry Down, for inclusion in their newsletter or on their website. This was drafted and sent by the ESIP lead. When the pilot opened up to all residents, this required a different level of messaging and promotion. Engagement was sought with the Public Health Communications team for higher tier promotion in particular. The ESIP lead drafted and shared a range of messages for use on the Hackney website, in newsletters and for social media outreach.

This transition was not flawless. It was not made easier by the short time frame, changes in self-isolation guidance and the shifts in accommodation availability for positive cases.

In August, a push was made for engagement in the City of London and the communications officer was instrumental in getting a press release prepared. This press release gained some

long-term traction when several people, including non-residents, called to ask about going into external accommodation after doing online research on isolation and accommodation. This was a sign the information was available online and people with internet access could find it. The fact that at least 3 calls were from out-of-borough residents also indicated this type of support was not widely available.

Another result of this press release was an online news piece followed by a freedom of information (FoI) request to find out the cost of the overall project and in particular the names and addresses of the accommodation providers. The FoI was dealt with but it illustrated that information can always be interpreted in different ways and that wording is important.

5.3.2 Outreach

In terms of outreach and awareness raising, the pilot's original promotional leaflet was distributed predominantly at testing pop-ups at Woodberry Down and Pembury estates, and through the mobile testing team. It was also shared digitally with a range of stakeholders, such as community champions and the Homerton Neighbourhoods Programme team (a hospital community outreach programme). Again, due to the change of scope of the pilot as well as the changing availability of accommodation, this leaflet was only accurate for a short period of time and needed updating and reprinting. The in-house design team was incredibly helpful with this but changing, proofing and printing take time.

English was the only language of communication, despite awareness having been raised at the outset that, for instance at the Woodberry Down estate, Turkish was a key language. After opening up the pilot to all of Hackney and the City of London, the wording on the leaflet was changed to reflect this but there were no translations of the leaflets or of the 'how to' guides. This was largely due to lack of time and the envisaged brief duration of the pilot but it can be seen as a shortcoming, especially if the intention was to make self-isolation support accessible to all.

Beyond frequent email contact with stakeholders to raise awareness and announce changes, 3 online project updates were held in July, August and October 2021. They were a platform to share information and progress and to actively invite feedback from stakeholders such as helpline call handlers and community champions.

Learning and challenges: communication and outreach

1. There is a difference between raising awareness among stakeholders and promoting a service: with the change in scope of the pilot a higher level promotion plan was needed but had not been anticipated.
2. If communication and outreach are done in one language, a project cannot state it has increased accessibility of services.

Section C. Evaluation data

This section presents the user data, support need, what the pilot offered, what the uptake was and how the support was perceived by users. It will also touch on practical challenges encountered along the way and give examples of what worked well.

6. Pilot user data: general overview

The pilot ran from 8 July to 31 August, then with an extension through to 30 November 2021. This was a period of 20 weeks and 5 days. In total, 47 people called in to access ESIP support or were referred by someone else.

Table 2. Referrals into ESIP, number per month

Month	July	August	September	October	November
Number	7	14	5	7	14

To put this in context, a lot more people called about the grant application during this period.

Figure 1. Case numbers, calls to Helpline and grant applications

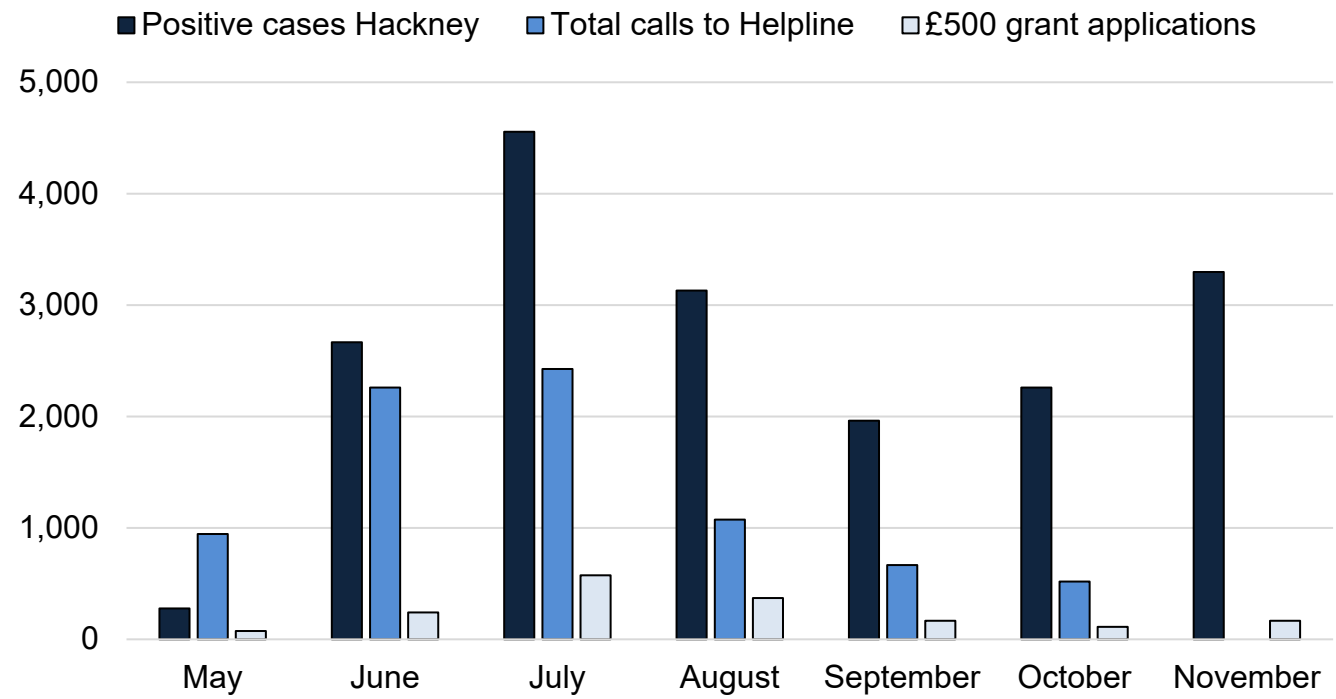
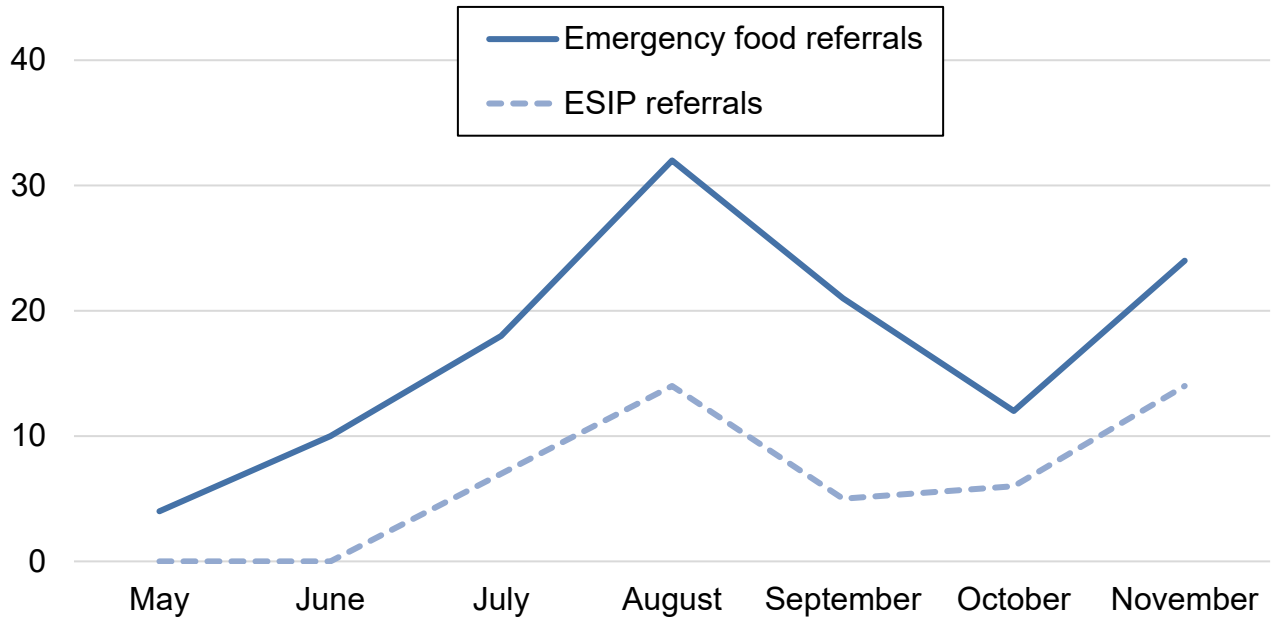


Figure 2. Food referrals and ESIP referrals



The numbers in Figure 1 should be interpreted with caution as not every call to the helpline is made by a COVID-positive person and repeat calls may be included. The low numbers in the line chart demonstrate that only a relatively small number of callers explicitly requested food support or enhanced self-isolation support. Perhaps many people needed financial support more than any other type of support, and there was a low need for other types of support. Perhaps not many people knew about other types of support available.

More insight is provided by the table below which breaks down the calls to the Helpline in percentages. Many called about vaccinations, for example, in certain months.

Table 3. Calls to the Here to Help Helpline, % of calls per topic, per month

%	May		June		July		August	September	October	November
Food		10.4		5.1		4.2	9.3	10.3	14.8	
Energy bills		4.4		1.3		1.1	1.7	3.4	4.9	
COVID-19 tests		10.5		4.7						
Self-isolation pilot						4	1.4	1.9	4	
Vaccinations		35.9		69.8		62.9	24.4	13.2	24.3	
T&T support payment		7.6		7		13.7	40.8	47.8	30	
Someone to talk to		8.4		4.3		5.2	7.3	5.4	8.5	
Anything else		22.8		7.9		5.6	11.1	14.3	8.7	

(November data not available from provider) legend:

0 to 5%
5 to 10%
10 to 20%
20 to 30%
30 to 40%
40 to 50%
50 to 60%
Over 60%

6.1 Cases or contacts

Of all 47 users of the pilot, 30 (64%) were positive cases, 13 (28%) were close contacts, 2 were both (close contacts who had turned positive) and 2 were of status unknown (for example, one caller chose to remain anonymous). With the change in self-isolation guidance on 16 August 2021 it can be noted that relatively fewer close contacts called in after 16 August.

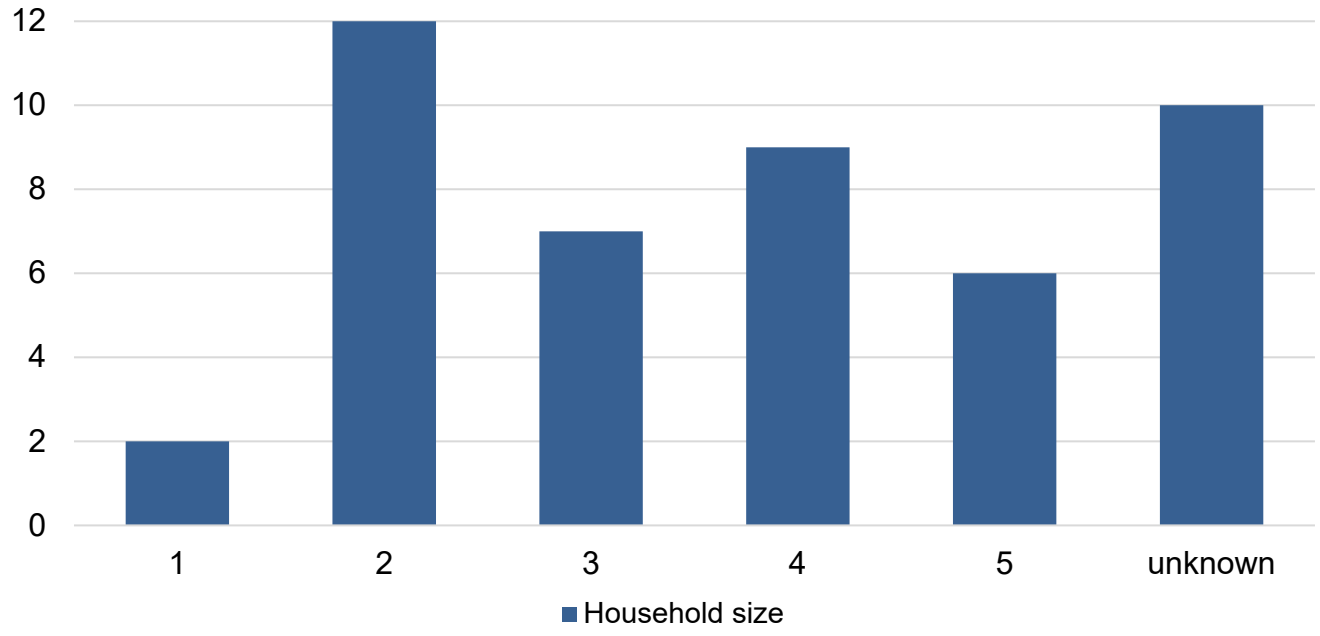
Table 4. Cases or contacts

	Case	Contact	Contact then case	Unknown
All users (n=47)	30 (64%)	13 (28%)	2 (4%)	2 (4%)
8 July to 16 August (n=19)	11 (58%)	7 (37%)	0	1 (5%)
17 August to 30 November (n=28)	19 (68%)	6 (21%)	2 (7%)	1 (4%)

6.2 Household size

In terms of household size, this information was not available or recorded for all users, especially when callers only called about (the status of) their self-isolation grant application.

Figure 3. Household size



Household size is of course important for the potential to prevent spread at household level. Not enough feedback data was collected to assess whether the pilot had an impact on onward transmission, but some case examples serve as an indication it may have, as highlighted in the box below. The 37 callers for whom household size is known represent a total number of 103 people. The support provided therefore did not just benefit a caller but also their household or family.

Preventing onward transmission

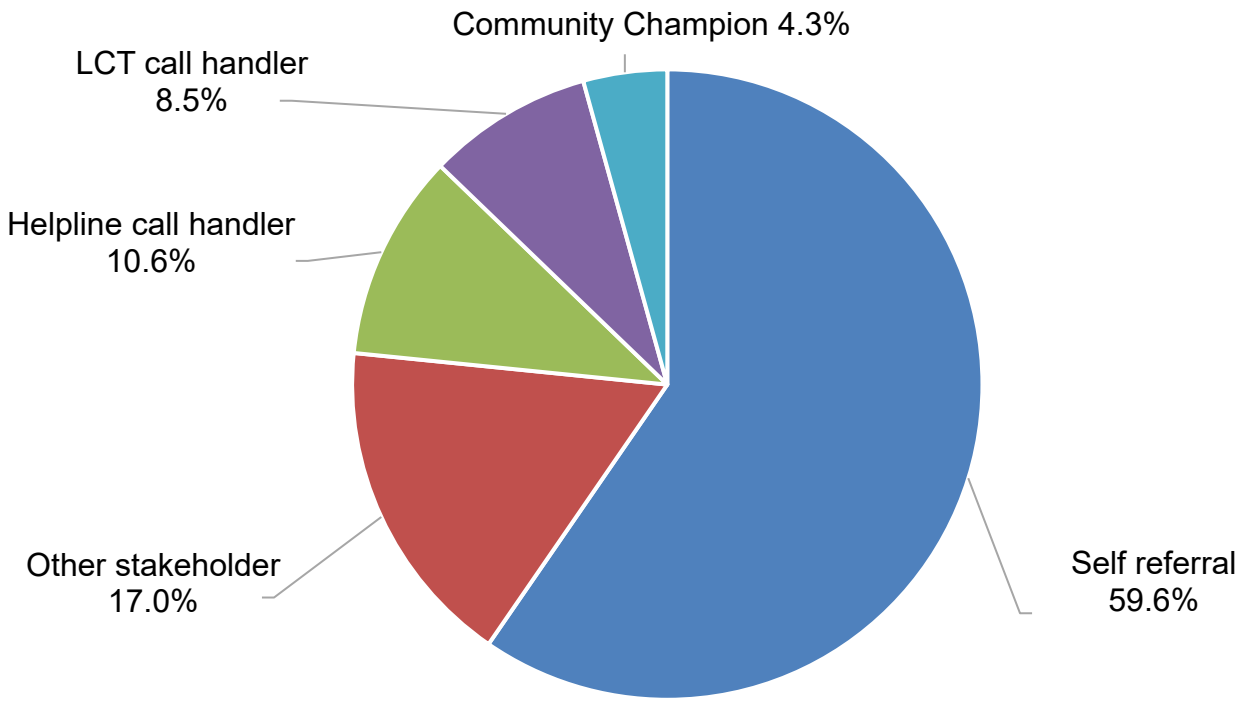
1. Close contact living with 2 positive cases felt unsafe and was offered to self-isolate externally. She completed her isolation period and remained negative.
2. A family of 4 with one positive child were provided with emergency food support, care packages, infection prevention control and some toys for the child. At the end of the isolation period no one else in the family had tested positive.
3. A woman in a tourist hostel tested positive. She was able to isolate in external accommodation. No one else at the hostel tested positive in that period. (total number of guests not known).
4. A man living with his mother and sister tested positive on LFT and requested external accommodation for fear of infecting them (the mother was a key worker with the NHS). He was accommodated within hours of his call and they remained negative.

The fact that the pandemic and the virus are constantly changing, as well as people's attitudes and behaviour in relation to it, should also be taken into account. For example, in November several calls came through from families where almost everyone had already tested positive and there was a need for food support, whereas earlier on in the pilot the calls were more often from one positive case in the household, worried about infecting others. This is of course observational and anecdotal.

6.3 Referral pathway

In terms of the referral pathway, all avenues were used at least once as illustrated in the pie chart below.

Figure 4. Referral pathways



This suggests there was awareness both internally (among call handlers) and externally (community champions, residents) about the support available. The majority of entries into the pilot being self-referred indicates that residents picked up on information as it was made available through leaflets, the Hackney website and newsletters. However, the numbers are relatively small – especially in comparison with the numbers of people applying for the self-isolation grant (see Figure 1) – and could equally suggest not enough promotion had been done. Or that actual need for support of this kind was low.

6.4 Knowledge about the pilot

When asked in the post-support survey how people found out about the service, the answers were varied, as illustrated in the list below.

Sources of information about the pilot

"Via the internet."

"Via Track and Trace."

"From the NHS."

"From Hackney services."

"From another community, ACS."

"From a family member."

"Email from Hackney or Hackney newspaper."

"From the NHS message system which directed me to my local borough support."

"Through work when I isolated."

"The NHS just sending me the link."

"Online article."

"Online."

"On the government website."

"My parent told me."

"My auntie also received support, she got called by the council when she had COVID, so she told me to call and see what I could get."

"I was googling how many people are self-isolating in Hackney currently and then found a news article about the pilot randomly on news.hackney website."

"I tested positive in the hospital when I gave birth to my child. I got connected to the council by Sarah who works at a charity I know and she told me I could get support."

"I phoned the council myself to ask for support; I found the phone number online."

"I called 119 or the council several times with no luck until the third time I was put through to Froeks who was extremely helpful, lovely, and made me feel supported when no one else was there for me; If she didn't work tirelessly to find me a place to stay I would have been homeless or would have had to lie about my status to find a place to stay."

"I am a community champion and was involved in the research phase before the pilot started."

At the assessment call, the ESIP lead also retrieved some information about how people found out about the pilot, which brought up a few other surprising entry ways:

Information about the pilot

"Referred by T&T or customer service call handler (3), benefits adviser (grant)."

"Was advised by test centre practitioner."

"Was given the number by Universal Credit via 119."

"A friend in Hong Kong sent her the info about support and helpline."

"A colleague asked about the possibility to help."

"Homerton Division Manager heard about project via hospital discharge team partner of case already being supported."

"Googled 'free accommodation, COVID, London' and saw the article in City News."

"Was referred by a community champion."

This shows that the information was in the public domain and people with access and ability to search online for local support had a means to find it. However, this does not tell us whether people without internet access or ability to search online would have known about it if they needed it.

The fact that call handlers, a grants adviser, a test centre practitioner, the hospital discharge team and 'a colleague' informed or referred people suggests there was a decent level of internal

knowledge about the pilot. Lastly, the fact that community champions did make some referrals shows the direct link with the community level, but at the same time, this number is quite low.

6.5 Identifying sources of transmission

The pilot set out to reach people faster by identifying positive cases sooner. As discussed in section 3.1, the pilot did not do pro-active case finding using the CTAS or Power-BI databases of cases for a number of reasons. This was mostly related to time and capacity in relation to need; the majority of cases do not require additional self-isolation support and therefore pro-actively calling all cases was unlikely to be the best use of limited time and resources. For example, in Hackney in July 2021 6.6% of positive cases indicated they were either clinically extremely vulnerable (CEV) or in need of some form of support with self-isolation, following the NHS Test and Trace trajectory.

Local contact tracing call handlers also had a full workload to contend with and there was a concern about capacity if they had to proactively find cases needing ESIP support. Instead, call handlers were briefed on the availability of additional support and encouraged to make referrals for those who indicated they needed more support.

In terms of providing the ESIP lead with access to said databases, the training trajectory for this was initiated but the overall workload of managing the project was such that there was not enough time available to do this.

Therefore, cases were not called proactively to assess support needs, but call handlers were aware of the available support and could refer people early in their isolation trajectory. This means it is not possible to say whether everyone who needed support was reached or was aware of the total support offer.

This illustrates the challenge of offering new interventions alongside existing commitments, especially the crucial task of contact tracing. Which in turn highlights that what is intended at the start of a pilot may not be what gets achieved.

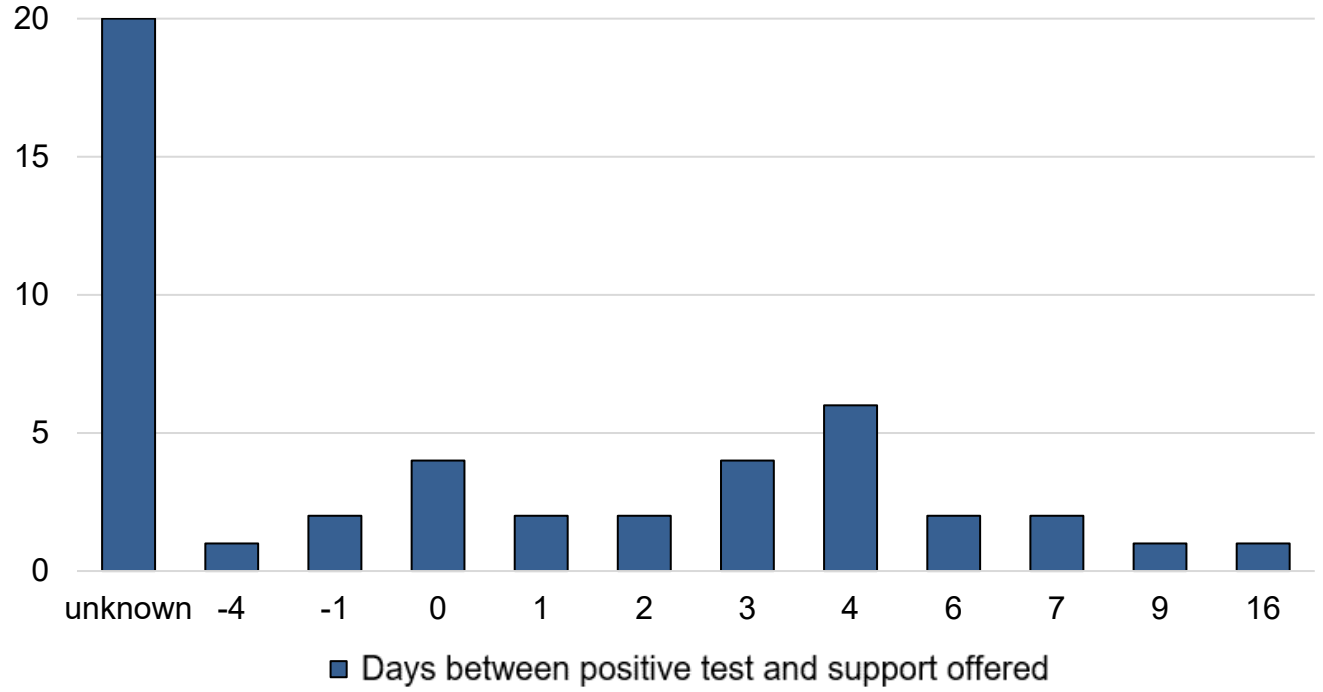
6.6 Time of entry into the pilot

People came into the pilot at different stages of their isolation journey. Some called for support as soon as they had tested positive on a lateral flow test, before awaiting the result of a PCR (something that is now standard practice, as per January 2022). Others called mid-way through their isolation period, needing food support when they had no support network to go shopping for them, or because they could not afford online shopping due to missing out on income. Equally, close contacts would call and not have a positive test date to report, or not know the exact date.

As the pilot also offered grant advice, a number of people called weeks after their isolation period, to find out what was happening with their grant application. In those cases test date information was not always recorded. Eight users called only to ask about their grant application status.

As such, the recorded info about days between positive test result and calling for support is varied, and insufficient data is available to say whether the pilot succeeded in reaching people sooner in their isolation trajectory, and potentially preventing onward transmission.

Figure 5. Days between positive test and pilot support



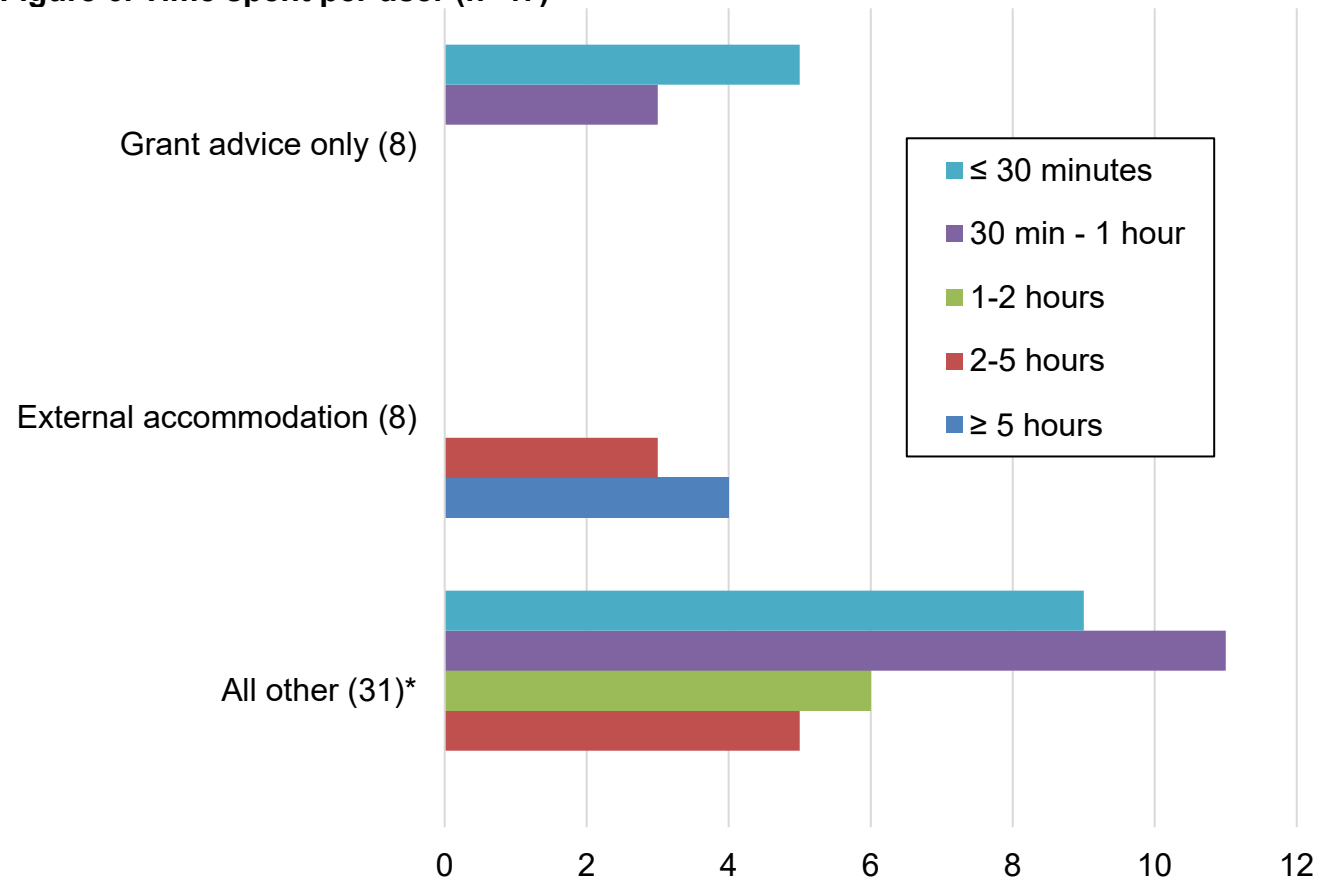
6.7 Time spent supporting people

Although not made overly explicit in the EOI, the pilot did also set out to “increase trust and satisfaction with the council”. This was an integral part of the assessment call, that is, the support triaging process. Providing a listening ear and making residents feel heard was important to establish trust and, potentially, strengthen a resident’s belief that the council cares. Once the pilot reached the implementation phase, the ESIP lead was able to dedicate sufficient time to supporting people, including by making follow-up and welfare calls.

Different users required more or less time: people who only called to check on their grant application status usually required less time than people who had a positive case in their household, needed food support and/or felt less able to cope and requested regular welfare calls. Most time was spent on users who were referred into external accommodation for self-isolation, as this was a process involving the arranging of transport, liaising with the provider of the accommodation, daily welfare check-ins, getting an Agreement signed and usually a food referral as well.

As such, involvement ranged from 15 minutes to almost an entire working day, spread out over sometimes almost 10 days. Especially with cases in external accommodation, this would at times involve weekend working to, for example, arrange transport, and daily check-ins.

Figure 6. Time spent per user (n=47)



* Food support, welfare calls, care packages, IPC advice and incidental support, often in some combination therefore hard to separate out

This type of time consuming and potentially intensive support is not something that can be offered routinely by Helpline call handlers who deal with high call volumes on a daily basis. The ESIP lead could spend the time that was needed on each case. The numbers illustrate that, apart from the cost of being able to offer external accommodation, dedicated staff time to manage the entire process represents a cost in its own right.

Throughout the pilot, no other person beyond the ESIP lead managed the process related to external accommodation, or offering any other complex combination of support, and therefore this is not something that has become embedded. This at times presented a challenge when the lead was on leave and cover was not provided as required. This also underscores the potential weakness of having a pilot being driven by one designated lead.

Learning and challenges: pilot user data

1. Numbers supported through the pilot are small in comparison to overall case numbers in Hackney over the total implementation period. Unclear whether this is a reflection of low need for enhanced support in comparison to, for example, financial support, or an indication that not enough people knew the support was available.
2. Multiple referral pathways were used which suggests knowledge about the pilot had trickled down to stakeholders, staff and residents.

3. ESIP lead being the referral hub and managing processes had strengths (time and execution) and weaknesses (insufficient familiarity with processes by others).
4. Some elements of the support were too time consuming for regular call handler duties.
5. The pilot was not able to evidence reaching people earlier in their isolation trajectory (case identification and needs determination).

7 Survey feedback

To collect the pilot users' views of the support provided, an online survey was sent by text message. In total, 20 people completed the survey or took part in a post-support phone call (some users preferred this to an online survey). This is a 42.5% response rate (n=47).
The survey asked questions about all the elements of support and respondents would only be expected to answer those sections that were relevant to them.

Below is a detailed overview of the support provided and how it was perceived by users.

7.1 Care packages

The care package evolved in the preparatory phase of the pilot when discussing the intentions of the EOI. Initially, the PCR test and the 'how to' self-isolation guides were seen as separate interventions but it became clear that an actual care package would be a practical way to facilitate self-isolation in the home and be a gesture of goodwill from the council. A care package contains:

- one PCR test
- pack of LFT
- PPE (masks, visor)
- hand-sanitizer
- self-isolation guides (developed for the pilot in consultation with residents)

Most items were already in store and supplied by DHSC. The addition of a thermometer and cleaning spray was intended but did not happen before the end of the pilot implementation due to issues with the purchase card.

The packs are assembled by the emergency stores manager and delivered by a logistics officer, who are part of the PH Health Protection, Testing and Logistics Team. Assembly and distribution are absorbed into their work package so this did not present a cost to the pilot. Overall, the care package is an item of low cost.

Care packages were accepted by 18 out of 22 service users who were offered this, out of a total of 47 users, which is a high acceptance rate (82%). An offer would not have been made, for example, if someone called to ask about their grant status and their infection was in the past, or where a person indicated they had enough supplies at home already.

Ten survey respondents provided feedback on care packages. Four answered that the care packages increased their ability to self-isolate while 2 said it increased their motivation to self-isolate. Five respondents replied that the care packages did not affect their ability or motivation. Others did not answer or were unsure. Seven respondents said they would use this service again and would recommend it to others and 9 said it was what they had expected. Eight of the 10 respondents said they used it for the whole period of their isolation.

Although these numbers are of course small, they are encouraging, especially regarding the length of use of the items supplied and the fact that the majority would use it again. Four out of 10 saying it increased their ability to self-isolate suggests this is a useful intervention.
When asked why they had accepted it, one person replied:

> “Because I knew I didn’t have COVID and my son did so we needed to clean and isolate from each other.”

One user answered why they would recommend it:

> “It helped me to stay inside. It also came very quickly, the package came straight away after I called, it was the first thing that arrived. Maybe leave out the tests as I didn't need them so much. But also not bad to have them.”

In line with the pilot’s intention to be adaptable and respond to user feedback, the contents of the care package were adjusted after some critical feedback:

> “Fast delivery and a lot of stuff in there. I didn't need all of it though and there was a lot of plastic waste.”
>
> (How to improve:) Ask what is needed.

> “Nice to have. Used the masks on the way back home which was a nice transition back into the real world as I know they are better than my fabric masks.”
>
> (How to improve:) Didn't need the apron and visor.

Following this, apron and gloves were removed from the care packages and 2 different packs were created, a ‘full’ pack that would contain all items, and a ‘basic’ pack that would contain only tests, masks and hand sanitiser.

7.2 Infection prevention control advice

The element of infection prevention control advice (IPC) – guidance on prevention measures such as keeping distance, cleaning surfaces in shared spaces, wearing masks inside, staying in one room, and keeping windows open – has perhaps been least outwardly explicit during the pilot. It featured in the assessment calls but was influenced by the nature of the call; a person asking about their grant status has long since left self-isolation and is not open to hearing about good practices at home. Or a single elderly person at home with COVID-19 who can't go out for food shopping is not sharing space with anyone and really just wants a food parcel to tie them over. It would also frequently be met with a 'yes I know about that already' response.

The IPC advice provided was usually linked to a care package referral as a means to encourage good self-isolation practices. There was no survey question about IPC advice as it was harder to define as a specific intervention, like a care package, and the length and depth of advice would have varied from one person to another, depending on their situation.

IPC advice remains an important overall element of self-isolation support, though people may be less receptive to it than towards a care package.

7.3 'How to' guides on self-isolation

The 'how to' guides for self-isolation were developed in collaboration with residents, mainly from Woodberry Down and Pembury estates. The intention was to give people accessible and tailored guidance and encouragement on a number of different topics to do with self-isolation, as set out in the EOI. The topics that were chosen, in conjunction with residents:

- keep your household safe
- sharing spaces without sharing COVID
- self-isolating with kids
- looking after yourself
- self-isolation support

Every A-5 leaflet had phone numbers, sources or links for local support. The design was in line with other promotional materials on COVID-19 already developed by the council. All leaflets had the Helpline number to request further self-isolation support.

The 'how to' guides became part of the care packages, so every household that received a care package would get a set of the guides. In total, 18 users received one or more packs. Seven survey respondents answered questions about the guides.

Three respondents said the guides increased their ability to self-isolate while 2 said it increased their motivation. One person answered 'unsure' to both questions. It did not affect ability or motivation for 3 and 4 respondents, respectively.

Only 2 people answered the question whether they would use this again, and both said yes. Five respondents said they would very likely recommend it to others, while one person said likely, and one said somewhat likely. As for their motivation for this:

(How to improve:) “Have them online as videos too on YouTube and the government websites to help.”

(How to improve:) “Not sure they’re good.”

“It gives you all the information you need and how to get support if you don't have someone. Also it helps you and give you hope that you are not alone.”

(How to improve:) “Nothing to improve.”

“Good to get extra information.”

“It helps you to understand more about COVID-19.”

(How to improve:) “It was okay for me.”

“Helpful.”

(How to improve:) “Not sure.”

“Useful.”

(How to improve:) “Not sure.”

As always with survey feedback, it is important to keep in mind respondents may give preferred answers rather than true opinions. When asked what they remembered reading, 2 respondents had feedback:

“The guides were nice, I remember a little story on back of one. It also showed all the help you could get.”

“All is good information”

Three out of 7 saying the guides increased their ability to self-isolate is promising but clearly the numbers are too low to judge the usefulness of this intervention. The limited preparatory time of the pilot also did not allow for producing the guides in different languages.

7.4 Welfare calls

As a support element, welfare calls were accepted by 21 out of 23 people who were offered this (91%), out of a total of 47 service users. Users who accepted self-isolation accommodation would automatically receive welfare calls as part of the council's duty of care. This is nonetheless a high acceptance rate. Reasons for not offering welfare calls would be if the person only called about their grant status, or if they only needed a care package.

The calls were free flowing and unscripted, informed by the needs of an individual user. They sometimes took the form of text messages, depending on the preference of a service user, or email if it involved information sharing. The ESIP lead used their personal mobile phone for text messages and out-of-hours calls, the latter predominantly to people in external accommodation. This flexibility was important to make residents feel supported but is not something that can be replicated by helpline call handlers.

Fourteen survey respondents answered questions about welfare calls. Four said that welfare calls had increased their ability to successfully self-isolate while one person said it had decreased their ability. In terms of motivation, only 2 respondents answered this question; one said it had improved their motivation, the other said it was unaffected. Thirteen out of the 14 respondents said they would use the service again and one said they would not, while 12 said the service was what they had expected, with 2 leaving this question unanswered. Eleven respondents were very likely to recommend this service to others, while the other 3 were neutral on this.

When asked why they would recommend it this was some of the feedback:

"It makes you know that there is someone that can help and hear your worries."

"Kind staff always who can always help."

"This is simple and very helpful service especially going through this hard time."

"It's good…Simple."

"I was happy someone called to check, it was nice that she showed concern, because some people just don't care."

"Important to know someone is checking in. My kids (with disabilities) depend on me so would be a problem if I would get ill too. Also nice to know you are doing the right thing."

"Nice to have to know I'm not forgotten about."

"It was good."

"Nice to have a professional person who can assure you that you are doing the right thing. Made me feel like I was under supervision, like a parent figure."

Although again numbers are too small to draw any general conclusions, it is encouraging that the majority of respondents would use the service again and recommend it to others, and that for about one in 4 it had increased their ability to get through the self-isolation period. That is a meaningful outcome. It also suggests that the personal approach, the intangible sense of feeling supported, is important even when nothing else can really be done.

Even though the calls were appreciated by most who received them, it is important to ascertain if people do want them; when people have to follow the self-isolation trajectory they often get multiple calls and texts from NHS Test and Trace and it can start to feel intrusive. However, there were a number of cases of parents (predominantly mothers) who were caring for children with COVID-19 or also had COVID-19 themselves who liked the fact that the call was for them, to ask how they were doing, both physically and mentally. It was an example of the council showing care towards residents.

7.5 Accommodation

External accommodation was an exceptional intervention and it was not suited to everyone or to all circumstances. However, when needed, it was a very valuable element of support. Accommodation was offered to 15 users and accepted by 8 (53%). This includes one emergency evacuation of a COVID-plus family due to a gas leak, which did not come through to the pilot as a regular referral but through the Civil Protection team.

Of the 20 survey respondents, 4 had made use of external accommodation but only 2 answered questions about it. This was likely due to language: when the survey was developed, the accommodation available was a hotel room. The survey therefore stated 'hotel' as the external accommodation option. Over time, self-catering apartments for positive cases became available. However, the language in the survey was not updated. The lesson learned is that, especially when faced with an often changing scenario, it is best to use neutral rather than specific language, that is, state 'external accommodation' rather than 'hotel'.

The 2 respondents said that receiving the intervention increased their ability and motivation to self-isolate. They would use it again and recommend it to others. When asked if the service was as expected, one said yes and one said no, adding that it was better than expected. In fact, they both said it was better than expected:

"Way better than expected. Was expecting regular room size but was really comfortable and spacious. Room size and facilities was part of fear when saying yes."

"It was better than I expected."

When asked why they would recommend it to others:

> “The accommodation was good, and the organisation to get food delivered as well! The wifi was not free so it was a bit difficult to work from there.” (see note)
>
> “Made everything so much easier, all my needs were provided for. Easier to adjust your mindset to staying inside if you're in a different environment.”

Note: After the pilot’s extension no suitable self-catering accommodation was available when an urgent case arose (a tenant positive for COVID-19 at the end of tenancy without the ability to stay on during his self-isolation period). This person ended up being accommodated by the self-isolation pilot in the borough of Newham. This apartment did not have free Wi-Fi.

The accommodation intervention was the costliest element of the pilot, with £54,000 of the total of just over £81,000 set aside for this. In actuality, the pilot spent approximately £25,282 on accommodation, including deep cleaning, transport and food. With 8 users supported this comes to an average spend of £3,160 per person. The families or households linked to these users also benefited indirectly.

In terms of preventing onward transmission, external self-isolation may have contributed to this on a few occasions: a case who was residing in a hostel spent almost her entire isolation period in external isolation and no cases were reported at the hostel following her positive test result.

Another case was a man who tested positive and did not want to put his family at risk. He moved into external isolation and his relatives remained negative. However, he himself got seriously ill with Covid and had to be hospitalised. This case illustrated the risks of external self-isolation, where a person is disconnected from their usual support network. This led to certain changes in the management of the cases, with daily check-ins (previously ad-hoc welfare calls), clearer clinical guidance and additions to the agreement with cases to include an emergency contact name and number.

The accommodation option was also costliest in terms of time, with 3 to 5 hours spent per individual. It includes considerable prep time to assess the suitability of the situation and the case (a tendency towards last minute ‘cold feet’, which was also recognised by the colleagues at Newham borough). An agreement needs to be shared and signed before transport is organised. A taxi to and later from the accommodation needs to be booked, the supplier of the accommodation needs to be liaised with and, usually, a food referral needs to be made. Then, the daily check-ins throughout the isolation period, plus sometimes other logistical issues, troubleshooting or reassuring conversations.

Overall, the intervention does not present good value for money but has been of great value in individual circumstances as is highlighted in the case stories below.

Case stories A and B

Case story A (before 16 August 2021)

A young female had just started a position as an au pair with a mother and her young child. Three weeks in, she tested positive for COVID-19.

Her employer, also her landlord, did not take kindly to being told that she (the employer) would have to self-isolate and shouldn't go out and meet up with friends (see note). She subsequently gave the au pair 3 weeks to leave, effectively evicting her, whilst ill with COVID-19. The au pair called the helpline and was audibly anxious and nervous. She requested to continue the conversation by text message for fear of being overheard. At this stage, the project had secured accommodation for positive cases which she was offered. She was able to complete the remaining time of her self-isolation in an apartment and was able to recover in peace and without fear.

Note: The au pair remarked the woman had been verbally abusive and felt having to self-isolate was against her human rights.

Case story B

A young male who had tested positive for COVID-19 and was nearing the end of his tenancy called the helpline as he was running out of options. His landlord was unwilling to let him finish his isolation period in his current place. His new lease was not starting for another few weeks, during which time he was going to visit his family abroad. The young man could not go and stay with friends as he didn't want to expose them and equally they were not keen to have him staying with them. He felt very worried he was running out of time and didn't want to lie to get into an Airbnb.

In his words: I had nowhere else to go as the contract on my flat ran out during my isolation and the landlord didn't care and just kicked me out as he didn't have a legal obligation to let me stay longer due to my need to isolate

His request for support came when the pilot had been extended but accommodation was not yet secured, and the regular provider did not have availability. After much fruitless searching for accommodation that would accept a positive case, the ESIP lead contacted PH colleagues at Newham to ask if their isolation accommodation had a vacancy, and they did. The Newham team agreed to accommodate the Hackney case and he completed his isolation period in one of their apartments. He was contacted daily by the ESIP lead by text message. He was also supported with a food referral and transported to and from the venue.

From a health protection standpoint, the public health impact has been negligible and this intervention would be too costly to keep on retainer as a standard support measure, especially

at borough level. Depending on the policy goals regarding isolation support going forward, it could perhaps be pursued at a regional or pan-London level where it aids public protection.

7.6 Self-isolation food support

Food support was accepted by 16 out of 20 (88%) who were offered this, out of a total of 47 service users. It was needed mostly as people had run out of food and had no support network around them to shop for them and were on low incomes.

As an existing intervention, this was also accessible directly through the helpline.

Nine respondents answered questions about the food support they received. Seven out of the 9 said they had used it for the entire period of their isolation. Six respondents said the food support increased their ability to self-isolate, while 3 people said it increased their motivation. The other respondents were unsure or reported it didn't affect their ability or motivation. Two respondents stated they would use the service again, and that it was what they expected. The other respondents did not answer.

When asked why they had requested the food support, these were the explanations:

"Obviously couldn't go to the shop as I had to isolate and was home alone with my children."

"Needed it – no cooking facilities in hotel."

"I couldn't go out and get my own."

"Delivery was very good, amazing. The food was very good and was really helpful when you can't go out of the house. The food was the main thing I was thinking I could get. If not I would have asked someone to get food for me but this was easier and meant I didn't have to bother people."

"Could not leave my home as I'm a single mother."

"Because we had no possibilities to go shopping."

"Because I was self-isolating."

"Because I was running out of food and had nobody to give me food except this offer."

Seven respondents replied they were very likely to recommend the service to others, with one responding 'likely' and one 'unlikely'. There were some comments to accompany this:

"It was all budget items."

"You will receive food if it is in need."

"Helpful."

"It was necessary."

"I think it was fabulous. The food arrived the next day and the food was lovely. They checked with me what I wanted and that's what I got so I can't complain."

"Very helpful."

"Amazing help."

"Good selection of food varied and some nutritional value. Pretty cushty. Nice to have a choice."

When asked how the service could be improved the following was suggested:

"Food voucher."

"Call the person and ask what they will need."

"Provide vouchers for food as well."

"Having a list of options, or asking for a detailed list via email."

This shows there was some variability in the (quality of the) referrals, which can be explained by the fact that different providers were used depending on the day of the week (weekday versus weekend) and whether someone was in external accommodation. The issue of quality of food parcels has already been addressed by the strategic delivery team who managed this programme with local community partners during that time.

It was thought that after the change in self-isolation guidance of mid-August, food requests would drop as fewer people would be obliged to self-isolate. In the period 8 July through to 16 August (less than 6 weeks), 7 food referrals were made through ESIP. From 17 August through to 30 November, which is a much longer period (15 weeks), 9 referrals were made. Although overall the numbers are probably too small to draw any conclusions about this, there were relatively fewer food referrals after 17 August.

The fact that for 6 out of 9 respondents the food support increased their ability to isolate is meaningful, as the purpose is to help people adhere to self-isolation guidance.

7.7 Support with accessing £500 grant support

This was an existing service available through the helpline that was included in the overall ESIP support offer. A total of 16 people out of 17 who were offered, accepted support with this (94%). Eight of the 17 called in specifically to ask about the status of their application and did not require any other type of support. Three of the 8 were awarded the grant.

Only 3 of the 20 survey respondents answered questions about grant support.

Asked whether this support affected their ability and motivation to self-isolate, one stated it had increased, one that it had decreased and one said they were unsure. Although they all said the service was what they had expected, only one would use it again, one was unsure, and one would not. When asked if they had actually received the grant, one said yes, one said no and one had not actually applied for it yet. Much in line with this, one was very likely to recommend it to others, one unlikely, and one likely. Their reasoning was as follows:

> “I don't like the way you take longer to reply why.”
>
> (How to improve:) “They have to improve financially.”
>
> “I didn't apply yet so I am not sure how to recommend.”
>
> (How to improve:) “Not sure.”
>
> “It’s helped me pay my bills.”
>
> (How to improve:) “More money.”

When asked how long it took to get the money:

> “It take 2 months and I fight for it they twice time rejecting me and they're asking me so many document to provide.”
>
> “About 2 months.”

The table below shows many more people applied for the grant than sought support through ESIP (Figure 2).

Table 5. Grant applications made and awarded, May to November 2021 (correct on 8 December 2021)

Month	Number of applications received (without duplicates)	Number of payments made	% of payments in relation to clean applications
May	47	19	40.4%
June	207	15	7.2%
July	547	24	4.4%
August	358	52	14.5%
September	146	81 (see note)	55.5%
October	113	55	48.7%
November	165	21	12.7%

Note: The payments made do not necessarily relate to the applications made that month as it takes a while to process an application. The higher numbers in September, for example, were due to clearing of the backlog created earlier in the year.

Behavioural research done before the pilot and other studies (COVID-19 support study experiences of and compliance with self-isolation: main report and Support for self-isolation is critical in COVID-19 response) have shown that financial worries or the risk of losing jobs are key factors that can stop people from adhering to self-isolation guidance.

Some of the most frustrated and distraught calls were from people waiting to hear about the grant application. This case story is an illustration of this.

Case story grant support

When his girlfriend tested positive, a man followed the guidance at the time (July 2021) and stayed home for 10 days to self-isolate. He was employed through an agency, doing fairly ad-hoc but regular work for a local council. He did not get paid because he was not working during his self-isolation period.

He made an application for the £500 self-isolation grant on 21 July 2021. By 9 August his application had not been assigned to a case officer. Although he was out of isolation, he didn't have the money to travel to work (almost £10 a day) when spoken to on 10 August. He was in debt from borrowing money to tie him over, and as the conversation continued he became increasingly distraught. He wanted to work but couldn’t afford to travel there. He wants to contribute child support but can’t. He has had to borrow money from friends and is now in debt. He did the right thing by staying home and feels he is being punished for it. When further inquiries are made, he has been assigned a case officer and is asked to send payslips, which he doesn't have because he was not working due to being in isolation. He needs to send an explanatory email and the T&T payments team will follow up with his employer.

Through the pilot he is referred for help with paying his electricity bills through the Fuel Voucher scheme – a small practical element of support that is all that can be offered at that time.

When checking on his application status some weeks later he had been successful and was eventually awarded the £500 grant. This was a positive outcome but the delay, the financial insecurity, the worry and the borrowing of money turned 10 days of isolation into several months of stress.

Not being an expert in the area of the grant, the ESIP lead did not always feel able to add value to this particular intervention beyond providing a listening ear. The lead would gather specific information to update callers, but this required support from the T&T payments team, which was quick and helpful. Although the 'friendly gateway person' was usually appreciated, it seemed more useful if the callers got connected directly with someone able to deal with their queries, as is the case with the Helpline (option 5).

The discrepancy between applications made and grants awarded, even if due to backlog, merits a deeper understanding of the process and where applicants fail. It may be worth dedicating some resources to investigate this, or to improving the process.

7.8 Incidental support

Incidental support is a collection of other resources that include craft packs and toys for children, energy vouchers, and onward referrals to other organisations such as the Shoreditch Trust, NHS Volunteer Responders or support services as listed in 'Better Conversations' and Find support services. The ask or need would be determined in the assessment call.

The toy option was a new intervention for the pilot; the other services could already be accessed through the helpline.

In total, 10 callers received a form of support, or in combination, under this category. Four households received toys, 4 received a fuel voucher, and 4 were referred to other services.

Four survey respondents stated they had received additional support, though only 3 of them answered further questions in this section.

When asked what other support they had received, they said the following:

"I was sent some toys which was a real special bonus. The kids were excited to receive them and we've still got them. If the kids are happy the mother is happy. They were also age appropriate gifts so very personalized and nice. The surprise was very nice, wouldn't expect from council. The food was kind of standard but this was a really nice surprise and helped me keep the kids happy."

> “I received a puzzle for my child.”
>
> “Receive craft kits for my daughters.”

In terms of ability and motivation to self-isolate, 3 said this support had increased their ability and motivation, and that they would use this service again. Two said the service was what they had expected, and one said not – that it was better than expected. In fact, 2 respondents said it has exceeded their expectations:

> “Their supper exceeded our expectations!“
>
> “Didn't expect it so exceeded expectations.”

Similar comments were made in welfare calls with families who had received toys.

Although the ability to self-isolate increased for 3 of the 4 respondents, these numbers are too low to assess how impactful this intervention was. For the individual families who received toys, where sometimes a whole family had COVID-19, it made a difference to managing their household. It also showed them that the council cares.

Learning and challenges: survey feedback

1. Overall number of people supported and respondents to the survey are too low to evidence whether the support provided reduced household transmission or contributed to people's adherence to self-isolation guidance.
2. Survey feedback and anecdotes suggest that on an individual or household level, the interventions helped with self-isolation and made people feel supported.
3. Majority of survey respondents would recommend the support received and use it again which suggests the interventions were useful and appropriate and should be continued if feasible.
4. The demand for financial support far outstripped other support needs, including food support.
5. Providing accommodation for self-isolation was an expensive and time-intensive intervention that had strong individual benefits but did not provide a larger public health benefit.

Section D. Key learnings and recommendations

Reflection

The COVID-19 pandemic changes at such speed that interventions that may have been useful 6 months ago may have lost their meaning by now. The current government direction (January 2022) towards living with COVID-19, combined with the frequently changing guidance for self-isolation and the ubiquity of the Omicron variant, seems to call into question the relevance of certain interventions trialled in the pilot.

There is of course value in learning, as other pandemics or infectious disease emergencies may occur in future, or yet another variant of COVID-19 may occasion the need to stand up enhanced self-isolation support.

Key learnings

The learnings relate to the support provided and how it was perceived as much as to how the pilot was set up and implemented. They relate to time, logistics and practicalities, and to partnership working and stakeholder engagement. They also relate to the friction between what is intended and what is achieved, and to bridging the gap between knowing what is needed and by whom and providing it in an accessible manner. The latter in particular is an ongoing challenge of achieving equitable public health outcomes for all residents.

The learning for DHSC is in terms of how the various pilots have played out and potentially improved life for residents throughout the UK, and which elements in particular would be suitable for replicating or scaling up. For the City of London and Hackney public health team the learning is in how to stand up enhanced self-isolation support and merge its benefits into wider self-isolation support, and also to find what the limitations are.

With a 5-week preparation period and an initial implementation phase of 8 weeks, time was an issue and affected codesign, partnership working, outreach and preparation overall. The project lead being new to council working did not make this easier. This could be addressed by either setting a more generous timeframe for preparation and implementation or by assigning staff who have prior experience of council working and existing relationships with key (internal) stakeholders.

Partnership working was crucial and much was achieved through collaboration, yet lack of engagement, conflicting priorities or simply lack of time and team capacity in any partner will reduce the effectiveness. Having a designated pilot lead meant there was a strong focal point and central initiative, but also increased the chance of it being seen as stand alone. Lastly,

logistics and operational elements are rarely highlighted but are the nuts and bolts to make implementation happen.

Conclusions

The pilot succeeded in supporting individuals at the household level but had no discernible impact at the population level.

The support offer was comprehensive and the user feedback was predominantly positive, yet communication and awareness about the support could have been better.

Policy, scope and accommodation changes affected implementation by delaying communication and messaging. Overall, bridging the divide between support need and offer was not achieved.

The demand for financial support was higher than for any other type of support as evidenced by calls to the helpline and grant applications. As a tool to enable self-isolation, eligibility criteria and processes need to be clear and easy to understand.

Providing external accommodation for self-isolation is a costly and time-consuming intervention that cannot be sustained by one local authority but could be useful as an intervention at pan-London or regional level.

Recommendations

General advice to ensure learning is embedded:

- for DHSC to reflect on and share the collated learning of all pilots
- for the City and Hackney Public Health team to share the learning internally and to be able to stand up enhanced self-isolation support as and when required

Specific recommendations based on the City and Hackney Public Health Team ESIP experience:

- a simple and easy-to-manage system of providing care packages promptly works well, and local authorities could be funded to do this during periods of lockdown or when isolation is required
- accommodation provision does not work well at the borough level. If this is to be sustainable, it would need to be at a bigger geographic footprint, for example, London-wide
- any programs for isolation support need a generous amount of time to be designed and implemented, as the leads will need good relationships with a wide variety of stakeholders – these take time to establish

- although some of the interventions are quite low cost, they require dedicated staff time to oversee; this needs allocated funding and would otherwise be difficult to integrate with local authority business as usual

Beyond the pilot: integration of enhanced self-isolation support

Extending the pilot after 31 August had a number of advantages beyond being able to continue the support. It allowed for deepening of relationships with existing partners such as community champions and helpline call handlers and building new connections with, for example, the Hospital Discharge team. The main advantage was the time it provided for embedding the support offer.

Management of the food referral system was transferred to Public Health and is now coordinated by the former ESIP lead. The food consortia delivering the food can also offer care packages.

By liaising with the helpline especially, broader self-isolation support is now provided to all callers who need it. In particular, call handlers are routinely offering care packages. The Health Protection, Testing and Logistics team is indispensable for the assembly and distribution of the packs and for continued awareness raising about self-isolation support.

Annexe 1. Tools and assets for ESIP implementation

Scripts

- script for assessment call
- short script for weekend

(N.B. links have been removed as the documents contain identifying elements of the accommodation providers.)

Referral related

- referral guide for anyone who can make a referral – 'Enhanced self-isolation pilot referral guide'
- Referral form to be used when making a referral – 'Enhanced self-isolation pilot - referral form' (on Google forms)
- referral form to use when requesting a care package
- delivery guide for care packages (SOP for driver)
- emergency isolation food referral forms:
    - weekdays referral form
    - weekend referral form
- fuel vouchers
- energy referrals for energy vouchers via CAB

Printed materials

- promotional leaflet
- 'how to' guides

Accommodation

- agreement between council and person in accommodation

Evaluation

- post-support survey sent out to everyone who received a support offer or who called in to the pilot – feeds into the evaluation dashboard via the ESIP master copy Google sheet (which cannot be shared due to user data and GDPR)
- evaluation dashboard presenting all survey results

Annexe 2. List of stakeholders

Internal

Here to Help

Also known as' COVID-19 helpline' call handlers and manager, tasks to:

- mutual awareness and understanding of role of helpline and isolation support offer
- call handlers' ability and willingness to make ESIP referrals

Local contact tracing

Team call handlers, duty managers, tasks to:

- understand the role of LCT call handlers
- create awareness of isolation support offer and referral route
- willingness and ability of weekend call handlers to actively handle ESIP calls

Housing

Both Hackney Housing staff and Peabody Housing staff at Pembury, tasks to:

- provide information about estates, residents, demographics (pilot estates)
- be the link with residents in terms of awareness raising about the project, including direct communication via emails or texts to residents
- support with data collection (for example, number of messages sent to residents)
- HOs and Pembury Peabody staff can refer people into the pilot (this has not happened)

The City of London Corporation

- Department of Community and Children's Services
- Communications Officer

Strategic delivery (food referrals)

- gain understanding of the food consortia set up and referral process; introduction to consortia relevant to Hackney pilot sites; introduction to private weekend provider
- making use of this support offer via the various Hackney food consortia and the private weekend provider
- use referral form and awareness of correct follow-up with providers

Community champions (CCs)

- liaison with PH and Hackney VCS staff managing the CC
- create awareness among CCs about the project (pieces in newsletter, participation in online meetings)
- CCs are able to refer people into the pilot

Communications

- support with promotion of the pilot at various levels, especially after shift from ‘pilot sites only’ to ‘all of borough’ approach
- input or guidance on messaging
- reliance on higher level press, media or web promotion

Design team and printing

- design and redesign of promotional leaflet, referral guide and ‘how to’ guides
- printing and reprinting of materials

Business support

- purchase orders
- processing invoices (accommodation and vouchers)
- Love2Shop vouchers
- purchase card support

Finance

- overall guidance (cost centre, invoicing)

Procurement or commissioning

- guidance on STAs and contract extension
- correct procurement processes

Civil protection

- link with central booking service Agiito/CMAC (transport for people using accommodation, potential of hotels for people who are COVID-positive)
- support with booking of transport when necessary (start-up problems with booking)

Emergency logistics

- assembly of care packages
- distribution of care packages
- support with accommodation logistics (for example, collecting or dropping apartment keys, personal belongings)

- support with collection and distribution of printed materials (leaflets, 'how to' guides)
- stock keeping of toys
- distribution of toys

Testing team (mobile and static)

- awareness about the isolation support offer
- static testing site manager makes referrals for incoming calls to Helpline option 3
- handing out leaflets at pop-up testing sites

Hospital discharge team

- liaison on discharge of patient into a family home with COVID-19 (one-bedroom flat for 4 people)

T&T payment team

- when callers want advice regarding the grant application feedback is requested and has been provided by a member of the Triage team
- T&T standard rejection email had a reference to the non-financial ESIP support

External

DHSC/UKSHA

- funders of the pilot
- weekly or fortnightly catch-ups
- policy guidance
- evaluation guidance

Voluntary and community organisations

- Woodberry Aid (community support and food aid at Woodberry Down, also CC)
- WDCO Woodberry Down Community Organisation (Independent Tenant and
- Leaseholders Woodberry Down)
- Manor House Development Trust (food consortium)
- African Community School (CAN) (food consortium)
- Shoreditch Trust (food consortium and wider needs support)

Homerton Neighbourhoods Team

- raising awareness about support for residents

Accommodation

- hotel A (first secured provider for both cases and contacts, cancelled shortly before planned launch)
- hotel B (close contacts)
- provider of self-catering apartments for positive cases

Other boroughs that have been engaged with

- Newham
- Havering
- Lambeth
- West Berkshire
- Ealing
- Cheshire East

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