UK Health
Security
Agency

Somerset migrant workers testing pilot

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Summary

This report was originally designed to share the findings from the Somerset migrant testing pilot; however, useful learning from working with Somerset Local Authority emerged during the course of the pilot and this has also been included.

The migrant workers pilot testing pilot was initially intended as a series of pilots at different food manufacturing and general manufacturing sites across Somerset; in the end just 2 sites conducted testing – a food distribution hub for Morrison's in Bridgwater and Cronite, a castings foundry in Crewkerne. The sites were selected because they had a high proportion of migrant workers.

This report includes the key findings from both qualitative[1] and quantitative[2] data collected from a site visit to Cronite on the 26 May 2021 which included observational research, 5 interviews with participants and subsequent at home testing data. Quantitative data were also collected from Morrison's.

Further qualitative data were collected from 4 interviews with the project stakeholders – 3 from Somerset Local Authority and one from one (of the 2) community engagement partners – and have been reflected in the Findings section below. The interviews were transcribed and the data coded to identify themes, this was an iterative process as data were repeatedly reviewed and themes emerged.

Context

Migrant workers, particularly low-wage workers, are at greater risk of getting infected with COVID-19. Those infected are at greater risk of more serious illness. They are more likely to live and work in densely populated environments, and they are more likely to be in direct contact with others and share tools[3]. Their access to health care and benefits can be reduced because of cultural, communication and policy barriers.

They are more likely to have short-term employment, low-skilled jobs, earn lower wages, receive no sick pay, lack access to safety equipment and have jobs that are not flexible.[4]

1 This includes observations on site, interviews with staff.
2 This includes analysis of NPEX testing data.
3 A vulnerable workforce: migrant workers in the COVID-19 pandemic
4 Migrant workers, essential work, and COVID-19

The pilots

The project was scheduled to run for 12 weeks from May 2021 and was conducted in partnership with Somerset Local Authority with the intention of targeting migrant workers. The first pilot took place at Cronite from 26 to 28 May 2021. The goal was to test as many staff – both factory workers and office staff – as possible. Staff were invited to take part in supervised lateral flow test (LFT) testing where assisted swab tests were administered by 4 technicians (from the local authority outbreak management plan team), overseen by a nurse. Participants were taken through the process of taking the test and registering their test results on the NHS app and downloading the app, if necessary. Participants were given a test kit of 6 tests to be take twice a week at home for 3 weeks subsequent to the pilot.

One other pilot testing site took place at Morrison's Depot, Bridgwater, Somerset. This testing was conducted on one day per week over 3 weeks in July and August 2021.

Evaluation

The objective of the pilot was to understand the engagement routes, socio-economic background, and barriers to testing and self- isolation within the migrant worker community is South Somerset. However, these objectives were not fully realised because of the low number of recruited organisations and a lack of project management. These findings are more fully explored in the Findings section, below.

The methodology included the use of semi structured interviews with both testing participants and the project team.

For the pilot at Cronite, respondents were recruited through opportunistic sampling: the interviewer approached people lining up waiting to be tested and asked their nationality then asked if they would be interviewed about their testing experience after their test. The interviewer also asked the technicians, who were part of the local authority public health team, to ask people being tested, who they believed to be migrant workers, if they would be interviewed.

Informed consent was obtained, from interview participants, and it was made clear to interviewees that participation was optional and that they could choose not to answer any question. In the event, all of those approached agreed to be interviewed and they were content to answer all questions. A translator from the community engagement partner was present to translate for the testing process and to help with any translation required during the interviews.

However, as it was necessary to have a translator present for most of the interviews there was a dependency on this person who also needed to translate for the testing process as well so the number of interviews that could be done was limited. No interviews were conducted at Morrison's, and we used the quantitative data from NPEx

The other stakeholders on the project (Somerset Local Authority and the 2 community engagement partners) were also invited to be interviewed. Three people from Somerset Local Authority were interviewed, 2 public health leads and a project manager. The CEO of one of the community engagement partners was also interviewed. The local authority stakeholders have been identified a PH1 and PH2 for the public health leads and PM for the project manager. The community engagement partner is identified as CE.

Findings

The findings focus, primarily, on the learnings from working with a local authority supported by the outcome of the testing pilots. The findings are structured around 4 key points:

1. Lack of clarity in the project.
2. The challenge of recruiting organisations to the pilot.
3. Good uptake of testing in only one organisation.
4. Test site outcomes.

Lack of clarity in the project

There was a lack of clarity in the definition of the project with an absence of a project plan and defined deliverables which impacted both the outcome and evaluation of the project.

A significant finding in the evaluation suggested that the departure of a key member of the local authority staff, who held the relationship with the community engagement partners, had a strong impact on the direction of the project:

> "I said I could submit something - what we could do - but at that time there were no formal parameters about what the project was about." (CE)

In the absence of defined deliverables, or project plan, there was clear frustration on the part of the local authority delivery team:

> "Internally, if we had had some directions and a plan from the beginning it would have gone smoother." (PM)

A project plan and defined deliverables would also have provided more accountability for deliverables and a clearer expectation from project partners as to their remit. In the end, the community engagement partner did some translation for materials at the testing centres and provided translation services at some testing days. They also contributed their own, existing, insights into barriers around testing gained from their own activity within the target community:

> "There was social media coverage. There were also little cards taken into testing centres so people doing the testing, so they had a quick way of communicating with people of other languages. …We did local messaging for testing which the council was running anyway. We did self-isolation stuff as well." (CE)

The value of community engagement partners' insights into, and knowledge of, the target audience was clear:

> "If I had to give you the issues: many people are getting information from their country of origin, and LF testing info varies enormously around the world depending on if it's available. The other issue is that if people's language skills aren't proficient people are worried, they'll be asked different questions that they might not understand and the fear about getting asked about their status in the UK." (CE)

Equally, this person knew about what claims could not be made:

> "But we have to be careful not to generalise, some people from other countries who live here are fluent and comfortable talking about testing and other complex issues." (CE)

However, these insights, and the value of the CE partner as a gatekeeper to the target community, were never fully realised. From the local authority side, the newness of the project team meant that there was little existing relationship with the community engagement group and there was little interaction during the project:

> "I would like to have been at a place every day…at different places, educating people, saving lives. I felt like things were discussed for a few weeks and then they said, 'forget about it we only have a few weeks left'." (PM)

Effective communication was another factor which contributed to the lack of clarity on the project. The main point of contact throughout the project was the weekly project meetings hosted by DHSC however these meetings had sporadic attendance. For the local authority team members who did attend project meetings, there was a sense of powerlessness of what they could do:

> "Those meetings (project) were uncomfortable because I didn't know the answer to those questions, but it was just me at the meetings." (PM)

However, this was at odds with the perception of how the project was being run by the public health partner who believed that she had:

> "Been leading on the project making sure we've had good links with DHSC, working closely with XXX and YYY and making sure we have someone steering the ship, it's my baby, I'm so interested in this project in getting outreach into this community." (PH1)

The challenge of recruiting organisations to the pilot

Despite the aim to engage with a range of different organisations to access migrant workers (such as faith-based, charity, community) there were clearly challenges around recruiting appropriate organisations to participate in the pilot:

> "Really time consuming, low success rate, difficult to justify your time. You call people up, explain the pilot, how it will benefit them. Then they would ask me to put it in an email. Sometimes they got back to me, sometimes they didn't so then I would have to follow up." (PH2)

Difficulties in persuading organisations of the benefits of testing was also evident:

> "Unfortunately, there was resistance – a lot of testing was coming to an end, some of it was about lack of understanding about testing, there was anxiety that we would have a direct link to immigration, so some said no, some said maybe." (PH1)

An additional challenge, in the recruitment, was to identify how many of the target group 'white other' (which served as a proxy for migrant workers) workplaces had:

> "Difficult to find out from leads about how many 'white other' workers they had, it was difficult to have that conversation, and you don't know if you're going off leads. We were asking later in the pandemic because we realised self-isolation was a barrier so we would ask how many of their workforce had English as a second language, but we had no idea about the numbers." (PH2)

There were also concerns about the approach to engagement with the target audience, within the timeframe of the project:

> "Building trust – the trusted face in the trusted space takes time, in a 12-week pilot not sure...do we have enough people?" (PH2)

Additionally, insights from the community engagement partners about where and how to engage with migrant workers were also voiced:

> "The hope had been to look for community-based testing, and I think there may have been assumptions made where all the Polish people hang out." (CE)

Despite the evidence of low number of workplace testing site, there were differing experiences, among stakeholders, about how successful engagement with workplaces was on the project:

> "Going through the workplace has worked, it builds up trust, if one person tests then it's compounding not sure we would have the same response if we had just rocked up to somewhere on the high street." (PH2)

> "So, I spoke to the assistant manager at Asda, and he said 10% of their staff were migrant workers and 80% of their shoppers. But then they didn't return my calls, or see me when I visited, they just closed me down." (PM)

Good uptake of testing in only one organisation

There was clearly a deeply felt commitment to the ethos of the project by the local authority, with an ambition to understand and engage with the target audience around testing:

> "I wanted to explore new avenues about supporting our community. Also working in collaboration to provide better information for the community, to translate materials into other languages, to understand the needs of others so we can better distribute information in the future…to understand the barriers to testing." (PH1)

It was envisioned that, to achieve this ambition, a range of organisations would be engaged with:

> "We wanted to have quite a spread – medium to small size businesses, faith groups, other community groups led by religious leaders, small business-like cafes, language schools. We wanted to get into established groups that were made up of white other." (PH1)

In the end testing only happened at 2 workplaces (Cronite and Morrison's) with very low take up and engagement at Morrison's, as the project manager who was present at the Morrison's testing elaborated:

> "I don't think they cared about us being there, the site manager walked past me in the canteen and wouldn't talk to me. I felt we were shut in the corner of the canteen, and they didn't care. [The community engagement person] got people talking to us but we were there one time for 6 hours and one person tested." (PM)

However, other members of the Somerset Local Authority viewed the testing as a success, which was in complete contrast to the experiences voiced by the project manager:

"Overall, we did very well, we got through to a lot of people who didn't speak English." (PH1)

Test site outcomes

At Cronite there was an awareness of testing informed by information from migrant workers' home country which was clearly valued but there were different levels of understanding of what testing meant and different levels of language competency which meant that people did not always go to official government and NHS websites to get information because these were perceived to be just in English.

Although broadly there was recognition of the value of testing there was some feeling of "being told what to do" (migrant worker 1), rather than being given a choice, which could be rooted in coming from a post-communist country, as the interpreter explained.

The technicians tried to encourage engagement by framing testing as an enabler: 'this means you can go to the pub' but there were varying levels of confidence around testing and an exit poll showed that not everyone was confident of testing at home and uploading results. This may have been attributed to some of the practical challenges encountered, for example many migrant workers had international phone numbers and devices which didn't work on the test registry app, technicians had to input the information and test results on work phones and data would come back to HR and it would then be communicated back to staff.

It was also evident that language was another practical challenge for migrant worker testing; it was necessary to have a translator to explain the process of testing and registering results which required a level of English that was beyond some of the people being tested.

Overall, there was evidence of taking a test as a responsibility to the wider group and the outcome of taking the test was that people "felt safer" (migrant worker 2) that they were not spreading the virus outside of work. There was also a sense of community at work in that people "didn't want to give it to others" (migrant worker 3).

A total of 112[5] out of a total approximate staff population of 143 people (78%) took one supervised test at Cronite, over the course of 3 days on site supervised testing. Of these, 29 (26%) identified as 'all other white' ethnicity. This group were mainly Polish migrant workers.[6] Of this group who identified as 'all other white', 14 had tested before and 15 had not tested before.

[5] Source: NPEX data

[6] A migrant worker is considered to be someone who is or has been working in Great Britain (GB) in the last 12 months and has come to GB from abroad to work within the last 5 years.

In the 3 weeks subsequent to the supervised testing, 12 people (41%) of this population went on to test on their own. There were no positive test results.

Five of the 12 who went on to test afterwards had not tested before the supervised test session at Cronite. Although these numbers are low, this does signify longer term behaviour change around testing. A limitation of this data is that we cannot know if the people who did not take the test in the initial on-site 3-day testing, subsequently went on to test.

There were also good levels of understanding of what self-isolation meant but it was clear it would be challenging for some who live in shared accommodation with other Cronite workers. It was also evident that there was uncertainty around support payments, from the local authority side, which were crucial to any discussion of the consequences of testing:

> "And the consequences of self-isolation for this group…I'm not sure if they will get support payment and if we're not sure then how will they take the risk and test?" (PH2)

For Morrison's only 25 people tested out of total staff population of over 1,000 (0.3%), of which 5 people identified as 'other white'; one person had tested before and 4 had not tested before, none of the 5 people went on to do follow-up tests.

More broadly on the project, the challenge of engaging with the target audience on the issue of testing alone, in comparison to vaccines, was noted by the public health team:

> "They're contacting these groups as much as they can and the area of testing is difficult to promote, not like vaccine where it's 2 commitments and you're done." (PH2)

This was also echoed by the CE partner:

> "I was surprised that the focus was only on LF testing and not more widely like vaccinations, self-isolation…they're the same barriers." (CE)

This was borne out at Cronite where migrant workers came with wider concerns than just testing with a desire to know about the vaccine passport and company's response to COVID-19. A successful outcome of the project included engagement with wider health interventions, as a result of testing, reported by the local authority:

> "Also, having a general conversation about COVID and change the information from anecdotal to factual. I'm thinking longing term, we're going to reap more benefits – encourage them to register with GP, for health checks maybe we can keep them healthier for longer. But difficult to quantify those objectives." (PH2)

The local authority were also able to provide insights to their vaccine teams, as insights about targeting groups for vaccination emerged as a result of engagement for this project:

> “We had meetings with COVID 19 response team, so we don’t duplicate work so as soon as we found out there was a common group that we were targeting for testing, which was more advanced then take up for vaccine. Now the vaccine group are going to go down the workplace group and I forward intel on to them for leads. Businesses are more engaged to have a vaccine clinic than testing.” (PH2)

The local authority also understood the impact of a positive test result for migrant workers and the employers and how this impacted take up of testing:

> “Some were worried that too many people would be taken out of work so although they seemed interested, they needed to know the consequences of a positive result so some backed out as they couldn’t afford to lose half of their staff and thought it was better to bubble rather than close down which from a PH perspective that was wrong, but you can completely understand where they’re coming from.” (PH1)

Discussion

The migrant workers testing pilot did not fully achieve its objectives to understand the engagement routes, socio-economic background, and barriers to testing and self- isolation within the migrant worker community of South Somerset. The absence of project management support, in the form of a project plan and clearly defined objectives, contributed to the objectives not being met but also underlies the lack of clearly defined relationships within the project.

Similarly, the absence of someone to ‘hold’ the relationship between the local authority and the community engagement partners, meant that insights from the community engagement partner around how and where to engage with the migrant worker population were never fully utilised and recruitment of organisations to engage with the testing program was low.

There were some insights into cultural and communication barriers gained from the program and, from one of the test sites, there was some limited evidence that people went on to test on their own after the supervise workplace testing event. However, overall, the project failed to deliver on the objectives but lessons on working with local authorities, including how to ensure accountability, could be applied for future work in this area.

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Published: March 2024
Publishing reference: GOV-15056

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