Supplementary Papers for Health and Wellbeing Board

Date: Thursday, 2 July 2020

5.	**BCP Local Outbreak Management Plan - Appendix** The Plan referred to as Appendix 1 to the report marked to follow is attached.	3 - 38

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BOURNEMOUTH, CHRISTCHURCH, POOLE (BCP) COUNCIL
LOCAL OUTBREAK MANAGEMENT PLAN

1 Introduction

1.1 BCP Council has a clear vision that we want to create vibrant communities, with outstanding quality of life where everyone plays an active role. The Covid-19 pandemic has interrupted our efforts to deliver this vision through an intense programme of activity set out in our Delivery Plan, but we are determined to re-establish our principles and direction, delivering real improvements for our communities through an effective recovery plan.

1.2 This Local Outbreak Management Plan sets out how we will work with our partners in health and the wider public services, alongside our communities, to manage a local outbreak of Covid-19, if it occurs, so that we do not deviate from our longer term objectives, but continue to deliver for our communities while managing the Covid-19 threat. I am pleased that this plan has been developed in close consultation with our partners in health, looking at the different levels of intervention that we will need to manage to keep our communities safe and healthy.

1.3 This plan gives us the ability to work with our communities to manage future outbreaks of Covid-19, whether that be an outbreak which is located in a specific building or location, one that involves active transmission in a community, or is more widespread, potentially affecting residents across a wider area. We have the ability, through this Plan, to manage any future outbreak to ensure the best possible protection for our communities. At the heart of our planning is the key issue of communicating with our communities, engaging with residents and businesses to control the virus if it occurs again within our communities and I am pleased that government has recognised the opportunity for elected representatives to play our role in leading this aspect.

Cllr Vikki Slade

Leader of BCP Council and Chair, BCP Health and Wellbeing Board

2 Working together

2.1 BCP Council has a clear vision that we want to create vibrant communities with an outstanding quality of life where everybody plays an active role. We can only deliver that vision if we have a clear an effective plan for dealing with local outbreaks of COVID-19. This Local Outbreak Management Plan sets out how we intend to work, with partners, to keep our communities safe and healthy should a local outbreak occur. This plan will assist the council by setting out how we provide leadership for our communities in this event.

2.2 Following the publication of the Government's COVID-19 recovery strategy on 11 May and the launch of the NHS Test and Trace service on 28 May, every local authority has been requested to pull together a local outbreak management plan by June 30.

2.3 In line with the Government's Test, Track and Contain strategy, the plan's aim is to prevent local outbreaks, and where this is not possible, minimise the spread of COVID-

19 infection and avoid the need for escalation to a national lockdown. Specific objectives in the plan include:

- responding to NHS Test and Trace information to support people to self-isolate quickly, working with Public Health England regional health protection teams
- supporting higher risk settings following outbreaks, including organising testing, and implementing infection prevention and control measures;
- developing and enhancing our local public health capacity
- providing data and surveillance to enable local leaders to take action to control the spread of the virus;
- Providing assurance and information to our communities about how we are preventing outbreaks, working with them on any local actions required. In doing so, enable a return to life as normal as possible, for as many people as possible, protecting our health and care system and promoting the recovery of the economy.

2.4 The BCP Council COVID-19 Local Outbreak Management Plan builds on existing plans to manage outbreaks in specific settings, and extensive work already underway in the council and the wider system in response to the pandemic.

2.5 The plan provides a high-level view across the system of the measures in place to manage and respond to outbreaks, working in collaboration with the Public Health England Regional Health Protection Team, Dorset Local Resilience Forum emergency planning response to COVID, and the BCP Health and Wellbeing Board, our COVID-19 public engagement board.

2.6 The plan is a working document, recognising that there may be gaps that we need to address, and to respond as national and regional guidance changes and we develop a better understand of our local picture. It will be published as an online resource, enabling users to navigate quickly to relevant sections – for example to access specific action cards, protocols and guidance about what to do in different scenarios.

2.7 Local Directors of Public Health are responsible for defining the measures and producing the plans, working through COVID-19 Health Protection Boards, in line with their statutory responsibility to protect and improve the health and wellbeing of the local population.

2.8 BCP Council will provide strong an effective leadership to our partners and communities should a local outbreak occur. We will ensure that the right level of response is in place whether it be a local contained outbreak in a specific venue such as a care home, a wider community based outbreak affecting a limited geographical area or wider sustained transmission throughout the community where we may need to work with partner councils if the outbreak extends beyond our boundaries. In all cases we will lead the response with our partners in health and the wider public sector.

3 Governance

3.1 Minimising the risk of local outbreaks and mobilising an effective response to those that occur will only be achieved through a combination of responsive oversight and

close partnership working across BCP. The following paragraphs outline governance arrangements and partnership working in BCP in the context of COVID-19 outbreaks.

Local outbreak management governance

3.2 Governance arrangements will vary depending on the scale of the outbreak, for example:

- Site specific contained outbreak will be led by the Director of Public Health, leading a partnership of health partners and the council working closely with Public Health England
- Sustained community transmission will require a council led SCG to be set up, probably chaired by the Chief Executive of the council
- Wider community transmission extending beyond the council's boundaries will probably require an SCG covering the LRF area, which may be chaired by the police as this plan develops, more detail on these arrangements will be provided.

3.3 Level 1 - local outbreaks manageable locally: Many individual setting outbreaks will be managed locally with public health advice and support from Public Health England and Councils. Many of these outbreaks have been in care homes where testing, tracing, self-isolation and infection control is reducing the number of cases, and the same teams are working to contain outbreaks in schools, workplaces and other settings. Hospitals and other NHS settings have similar teams working with Public Health England to control outbreaks. Typically, these outbreaks are being dealt with swiftly by local Directors of Public Health and often with the need for only short, temporary closures of premises.

3.4 Level 2 - Outbreaks managed between local and national: This describes the type of situation where an outbreak spreads into a local community, a wider set of resources may need to be deployed and greater engagement will be needed with the local community and stakeholders. The role of well-established emergency planning arrangements, with strategic coordinating groups, will be key where local arrangements, even with increased capacity, are tested. Where local capacity is exhausted and mutual aid is required, local capability is exhausted and additional expertise is needed, or where the outbreak crosses geographic boundaries. In these situations, tried and tested LRF arrangements will be key, along with the role of the NHS Test and Trace Local Teams to draw in national additional national capabilities as needed.

3.5 Level 3 - Local outbreaks with national implications: There may be some situations where local outbreaks will be of national significance. The NHS Test and Trace Local Teams will liaise between the local and national arrangements to develop a joined up and collaborative approach. Joint decision-making arrangements will be established to ensure Councils have access to the powers they need to contain outbreaks in these circumstances.

3.6 Examples of this might be: where powers held by the local authority are exceeded and a request for intervention from national government is required (e.g., a sectoral decision is required at a national level); multiple outbreaks that require resource

prioritisation by Ministers (e.g., where an outbreak requires more resources than local decision makers can access through their own systems or mutual aid, including supplies of items such as PPE or resources. These outbreaks may raise issues of national importance (e.g., impact on national infrastructure, the national economy or on important sectors such as food or energy production); or when local capabilities and controls are exceeded (e.g., local community protection actions are not effective, or local decision makers have not been effective in their management of them).

3.7 The governance diagram in Appendix A sets out the relationship between the BCP Council Health and Wellbeing Board (which will function as the Leader-led local COVID-19 Outbreak Engagement Board), the COVID-19 Health Protection Board (officer group responsible for public health response) and the Local Resilience Forum (LRF, providing a co-ordinated multi-agency response to mitigating the impact of COVID-19).

3.8 The COVID-19 Health Protection Board will play a central role going forwards in co-ordinating the public health response to local outbreaks. Work is ongoing to agree which elements of LRF work will continue to report into the response track, led by the COVID-19 Health Protection Board. Other LRF cells could be halted or 'moth-balled' in a state of readiness for re-activation as required, while other cells will need to report into the recovery track of the LRF. Key LRF cells that will continue to support outbreak management include testing, PPE, Health and Care Silver, the social care sub-group and the EpiCell.

3.9 The local COVID-19 Outbreak Engagement Board will provide member-led oversight of this local outbreak management plan. The proposal, for recommendation on 2 July, is that the BCP Health and Wellbeing Board (HWB), as a statutory Board, will take on this role. The HWB will provide regular public oversight to the plan at its usual meetings. In the event of a significant outbreak or incident the HWB will convene a sub-group to link with the COVID-19 Health Protection Board and with the Dorset LRF to ensure a rapid response can be deployed.

3.10 The Health and Wellbeing Board and its members will:

- provide political leadership and oversight of the Council's outbreak management plan
- communicate and engage with local communities pro-actively
- Link with specific communities, working with them to understand their issues and ensure that plans are based on evidence of what will work within communities.
- set expectations from the outset, including being clear on what is in scope for the local outbreak management plan, and what is out of scope.

3.11 Communications around outbreak controls and our planning will need to be clear and transparent. It will seek to reassure our residents, staff, business community and visitors. We will provide regular messaging on what the local data is telling us, what that means in BCP and how that will influence plans.

3.12 Other key decision-making groups include BCP Council's Incident Management Team which has provided tactical and operational decision making to support how Council services have responded to the COVID-19 major incident. CIMT will link to the Our

Dorset COVID-19 Health Protection Board so that any decisions requiring Council actions or resources are clearly recorded.

Local outbreak partnership arrangements

3.13 The prevention and management of local outbreaks will require collaborative working across a wide range of partners in BCP Council.

3.14 The Leader of BCP Council, as Chair of the Health and Wellbeing Board will lead on communication and engagement activities to encourage and support our communities to be vigilant against the threats of COVID-19 transmission. Depending on the scale of the outbreak the communications plan will be co-ordinated by the council's Corporate Communications Team or will build on the Warning and Informing communications partnership working established across the LRF during the lockdown phase in the case of a county wide outbreak.

3.15 Testing and contact tracing will require local plans to dovetail with regional and national infrastructure. This will require close working with the organisations involved in the Tiers of Test and Trace, as detailed in section 5 of this framework document.

3.16 A wide range of partners will be involved in prevention and response plans for high risk places such as care homes, education establishments and some local services / businesses. Section 6 of this framework document gives more detail on this aspect of the outbreak management plan.

3.17 A wide range of community organisations have been central to delivering support in communities through the lockdown phase of the pandemic, and much of this infrastructure will be used to support people required to self-isolate. Local ward members, local mutual aid organisations and more established community groups will all have a role to play in this next phase. More detail is provided in section 7 of this document.

4 Our Dorset COVID-19 Health Protection Board

4.1 The Our Dorset COVID-19 Health Protection Board has been established to maintain oversight and system wide vigilance around the status of COVID-19 infection rates across the Dorset Integrated Care System (ICS), in order to rapidly responding to any increase in cases or identify outbreaks in our area.

4.2 It is proposed that this COVID-19 Health Protection Board builds on the existing Dorset Health Protection Network which has been in existence since 2013 and has well established relationships across key organisations in the Dorset system, including:

- BCP Council
- Dorset Council
- Dorset Clinical Commissioning Group,
- NHS England Emergency Planning, Preparedness and Response Team,
- Public Health England (South West) Health Protection Team
- Public Health Dorset.

4.3 The COVID-19 Health Protection Board will be chaired by the Director of Public Health or nominated deputy and the membership will contain additional members from key COVID-19 related cells and groups which have been established through the course of the pandemic to date.

4.4 The Board will be supplemented as necessary by co-opting other key representatives of sectors when needed e.g. in the context of an outbreak in a setting such as schools, housing, care homes, prisons etc.

4.5 The inaugural meeting of the COVID-19 Health Protection Board was held on Monday 29 June to agree the terms of reference, membership and meeting frequency. It is suggested that the group meets weekly initially to establish the scope of the work, understand the COVID-19 situation across the local areas, establish processes for responding to outbreaks and identify any gaps to work on.

4.6 The COVID-19 Health Protection Board will be the key multiagency officer group responsible for surveillance of COVID-19 infections, and for responding to any local outbreak or COVID-19 related incident.

4.7 This board will report to the two Health and Wellbeing Boards in Dorset and BCP Council (which will function as Local Outbreak Engagement Boards) to provide oversight and governance of the Local Outbreak Management Plan for each Local Authority. This will allow the engagement of local communities through the elected members to maintain transparency and public understanding of the work that is going on or measures that need to be taken in response to COVID-19 in our area.

5 Informed by evidence and data

5.1 To support local decision-making and action we will need to be able to receive, share and process data to and from a range of sources in a timely way to enable:

- contact tracing and support
- infection mapping and surveillance
- local epidemiological analysis
- monitor effectiveness and impact of actions
- identification of local high-risk settings

5.2 Within the BCP area a wide range of information is already being pulled together to support the COVID-19 response. This includes:

- Surveillance and Monitoring dashboard - maintained by Public Health Dorset this brings together data from DiiS (Our Dorset Integrated Intelligence System), Public Health England and other external sources to support the identification of disease progression through the population and understand potential for future demands.
- Our Dorset Integrated Intelligence System (DiiS) COVID-19 Dashboard – maintained by the Intelligent Working Programme, this integrates data from local health organisations and care providers to support health care infrastructure and operational response

- A Dorset COVID-19 Insights dashboard - part of Our Dorset Population Health Management programme that is beginning to provide insight on our COVID-19positive and at-risk populations that enables health care professionals to support their patients more effectively
- Community resilience dashboard – part of the council's community resilience response that enables the local authority and voluntary and community sector to provide the right support to vulnerable individuals

5.3 As new national structures become more developed, new data flows are being established and continue to evolve. We will need to understand how we integrate this new data alongside our existing data, including data from:

- NHS Test & Trace
- the Joint Biosecurity Centre
- and Regional support teams

5.4 Surveillance and monitoring are overseen by a local Epidemiology Cell (EpiCell) which meets weekly, bringing together local intelligence and expertise from key settings/groups. The group currently reports to the Strategic Co-ordinating Group. This may change as LRF structures are reviewed. There will be a standing representative from EpicCell on the COVID-19 Health Protection Board. EpiCell will also report into any SCG called in the event that this is called in connection to an outbreak.

5.5 Members of the EpiCell also connect into the weekly PHE Regional Intelligence Call.

5.6 The EpiCell is working to identify key metrics which will offer early alerts to the system as it begins to recover to prompt review and early action if the level of infection in the local community begins to rise. This will be triangulated with information beginning to flow from NHS Track and Trace.

5.7 Key metrics currently being used as early warning signs are 111 call volumes for COVID-19 concerns, GP consultations for suspected cases, and NHS staff absence due to COVID. Analysis using outliers or variation in 14-day averages are being used currently, but we continue to review the most appropriate methods, recognising the issue of small numbers locally.

5.8 A current picture of data flows in and reports out is detailed in Appendix B. Local data flows are covered by local data sharing agreements, including the IWP/Population Health Management data sharing agreement. National and regional data flows are each covered by different data sharing agreements set out centrally. These may preclude wider sharing within the local system.

5.9 Discussion continues with regional and national partners to ensure we have access to relevant information in a readily accessible format that can be effectively integrated with local data. The need is for data to support analysis based on:

- population segmentation - sex, age, marital status, ethnicity, deprivation, employment status, employment type, place of work, place of residence.
- geography - residential address of case and probable location where infection acquired

- settings – cases connected to particular high-risk/complex settings, based on our current understanding, and any settings where a case probable infection location occurred
- Take action to manage outbreaks and support individuals:
  - Name and contact details for individuals who are asked to self-isolate and may need support to do so
  - Named settings where a number of cases are identified to enable support and action to be put in place.

5.10 Local action will also be informed by the national Joint Biosecurity Centre (JBC) playbook. This is a suite of Action Cards that are being developed by the national team at the JBC. These are there to inform and guide responses to situations based on current evidence. See the Toolkit section for details of the cards.

6 Local arrangements for testing and contact tracing

Testing

6.1 Access to testing is one of the key tools which we need to be able to rapidly and effectively respond to any outbreak of COVID-19 in our area.

6.2 As part of the response to tackling COVID-19, in April the Government published the National Testing Strategy: 'COVID-19 (COVID-19) Scaling up our Testing Programmes' . It is made of up the following five pillars (or workstreams)

- Pillar 1 – NHS swab testing. Testing of priority patients with surplus testing being used for critical NHS staff via NHS and Public Health England (PHE) labs.
- Pillar 2 – Commercial swab testing. Creation of new swab testing capacity delivered by commercial partners. This is mainly through drive through facilities and mobile facilities.
- Pillar 3 – Antibody testing. Developing testing to detect if people have had the virus.
- Pillar 4 – Surveillance testing. Undertaking population surveys to find out what proportion of the population have had the virus to inform decisions about social distancing and exit.
- Pillar 5 – Diagnostics National Effort. Building partnerships to deliver a large diagnostics industry to deliver mass testing at scale.

6.3 As part of the Dorset LRF structure there is a Testing Task and Finish group coordinated by a Dorset Testing Cell, chaired by the Chief Executive of Royal Bournemouth and Christchurch and Poole hospitals.

6.4 This multiagency group has worked effectively to roll out the range of testing offers which have developed so far over the course of the COVID-19 pandemic and will continue to evolve as the testing arrangements develop. Currently Pillar 1 and Pillar 2 are the key elements that support our Local Outbreak Management Plan.

6.5 It is proposed that a Testing Cell representative along with a military liaison representative who is responsible for the Mobile Testing Units (MTUS) are core

members of the Our Dorset COVID-19 Health Protection Board to ensure good connection and rapid deployment in the event of any outbreak or change in the need around the delivery of testing.

6.6 As our plan evolves, we will develop clear models for accessing rapid community testing, using the existing local capacity – a fifth of which is now under the direction of the Director of Public Health.

Pillar 1: Hospital based testing

6.7 Pillar 1 testing relates to that which is carried out within hospital laboratories and is primarily for inpatients in hospital and those patients who are due to attend for planned care. It is the hospital laboratories that provides the fastest turnaround of results (same day or next day at the latest), with the fastest turnaround being where one of our own local laboratories are being used.

6.8 Pillar 1 is available for some key staff members. Rapid Access Testing pathways have been established to test very urgent critical keyworkers (or their household members) in BCP. Requests, which need to have director level support and confirmation of critical key worker status, should be sent to covidtesting@dorsetccg.nhs.uk

6.9 The other important role of pillar 1 testing is to test patients for COVID-19 prior to their discharge from hospital if they are returning to a carehome or prison setting.

6.10 The capacity for Pillar 1 testing has increased significantly from the original total of 120 tests per day for all 4 hospital trusts in Dorset at the start of the Pandemic to a current capacity of approximately 224. This is supplemented by the capacity available at the Bristol Public Health England Laboratory which is now able to deliver test results within 24 hours.

Pillar 2: Department for Health and Social Care (DHSC) commissioned Testing routes.

6.11 Pillar 2 testing is made up of the following Department of Health and Social Care (DHSC) testing facilities in Dorset:

- A Regional centre which is a static drive through testing facility at Creekmoor Park and Ride in Poole – capacity for 1,400 tests per day
- Mobile testing facilities – two mobile units which are satellites of the Regional Testing Centre at Creekmoor each with capacity for 200-300 tests per day
- Postal testing kits

6.12 These testing sites are part of a wider programme being managed by the Department for Health and Social Care. Nationally all tests are requested via the online portals.

6.13 Postal home testing kits, which are ordered via the national web portal or helpline, provide an additional route for keyworkers and members of the public who cannot or would prefer not to use the drive through facilities.

The Regional Testing Centre and Mobile testing units

6.14 The population of Dorset is well served by the RTC and its two satellite mobile testing units and the aim is for residents to be able to access a pillar 2 testing facilities within a

30 minute drive. Whilst the Creekmoor facility is the main fixed site, it's two associated mobile testing units are more mobile and can be deployed to other locations where needed. They are currently rotating between sites in the west of the county and Somerset (Blandford, Weymouth, Bridport, Dorchester and Yeovilton) to cover the population which are a longer drive from the Creekmoor RTC.

6.15 In liaison with our military colleagues, these MTUs are an important tool as part of our response to an outbreak. The military representative for the MTUs in Dorset will be core member of the Our Dorset COVID-19 Health Protection Board to ensure good coordination and understanding of where the MTUs should be best located, particularly in the case of a localised outbreak.

Deployment of Mobile Testing Units

6.16 This guidance applies to the current provision of Mobile Testing Units (MTUs) by the Ministry of Defence. It is expected that in due course these MTUs will be replaced by a contractor solution, at which point this guidance will need to be reviewed.

6.17 By the end of June 2020, the number of MTUs will have increased sufficiently to allow each county area to hold a team in reserve. Should the relevant COVID-19 health protection board decide that localised testing is required within the next 48-72 hours, activation of the reserve Mobile Testing Unit (MTU) should be requested via DHSC *(contact details to be confirmed)*.

6.18 If the local testing is not required within 72 hours, the requirement should be passed to the regional testing planning group (currently sitting every Monday and Thursday) for action via the usual MTU planning process.

6.19 When requesting an MTU, the board should consider likely number of tests required, and availability of a suitable space for the MTU to operate from (including access to toilets, running water etc). Identification and set-up of a testing area will likely require coordination with local police or other agencies, to control traffic flow or access to the chosen site. In any case, a point of contact with knowledge of the local area and requirement should be nominated as a contact point for the MTU.

6.20 MTUs are trained and equipped to provide swabbing test from a vehicle in an open area. They are not trained or equipped to enter buildings or to provide testing in an indoor or enclosed environment, such as schools or care homes. Should testing be required in these conditions, testing would need to be led by appropriately qualified health professionals with the MTU providing support in an outside location such as a nearby car park. MoD MTUs are also not DBS screened and are thus not able to provide testing to children or vulnerable adults without provision of the appropriate safeguarding cover.

6.21 MTUs do not hold their own swabs or testing kit and will need to collect these from a Regional Test Site (RTS) before setting up a local testing area. On completion of the local testing, swabs will be returned to the RTS for onward transfer to a testing laboratory. As RTS are currently only open standard business hours, this may affect the times that MTUs can conduct local testing; they will need to travel to an RTS before closing.

Whole Care home Testing

6.22 Care homes have always had access to testing for residents and staff who are displaying symptoms of COVID-19 through the Public Health England South West Health Protection Team investigations of any suspected outbreaks. In recent weeks Care homes serving adults over 65 years old and those with Dementia have been able to apply to take part in "whole Care home" testing. This involves the testing of all asymptomatic staff and asymptomatic residents. This allows care homes to understand whether there are any asymptomatic cases who may unintentionally pass on the infection to other people within that setting.

6.23 Care homes can apply directly through the Government portal to organise their own testing. In addition, the Director of Public Health can submit their own weekly prioritised list of homes who the system would like tested. The results are fed straight back to the Care home manager and to Public Health England to be added to the surveillance data. From the 7th June the eligibility criteria was widened to include all residential care settings who look after adults, including learning disability homes.

Pillar 3 Antibody Testing.

6.24 The key testing route for our Local Outbreak Management Plan is through Pillars 1 and 2 to establish if and how many people are currently ill with an infection from COVID-19 in order to isolate and reduce the chance of transmission to other people. However, there is currently a large programme of work to roll out antibody testing to all NHS staff in Dorset. This will identify who have been exposed and have any antibody response to COVID-19. The results of this testing is currently not clinically or practically important as it is not known whether the antibody response is protective and if so, how long this immunity lasts for.

6.25 It is likely that it will be a long while until we know what this testing data means but there is an expectation that this programme is rolled out wider across key workers staff including the care sector which is why it is referenced in this Local Outbreak Management Plan in case further work is needed.

Contact Tracing

6.26 The NHS Test and Trace service came into operation at the end of May as part of the Government plan to allow the gradual easing lockdown restrictions. The test and trace service is important to this Local Outbreak Management Plan because it:

- ensures that anyone who develops symptoms of COVID-19 can quickly be tested to find out if they have the virus;
- helps trace close recent contacts of anyone who tests positive for COVID-19 and, if necessary, notifies them that they must self-isolate at home to help stop the spread of the virus.

6.27 Through the test and trace process any person with confirmed COVID-19 will be asked to identify close contacts from 48 hours before they developed symptoms and during the time since they developed symptoms. Close contact is defined as:

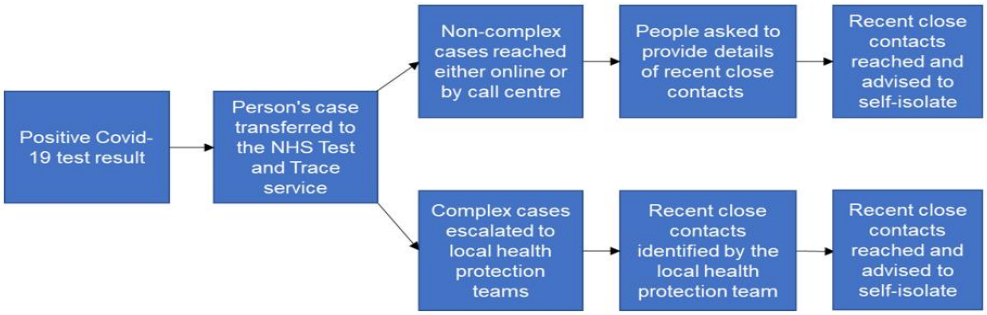
- having face-to-face contact with someone (less than 1 metre away) – this includes having a face to face conversation, being coughed on, having skin to skin contact, or any other contact within 1 metre for one minute or more without face to face contact.
- spending more than 15 minutes within 2 metres of someone
- travelling in a car or other small vehicle with someone (even on a short journey), or travelled close to them in a large vehicle or on a plane

6.28 Any close contacts will then be asked to self-isolate at home for 14 days and not leave the house for any reason, regardless of the results of any subsequent testing for COVID-19.

6.29 Where staff in clinical or care settings are wearing PPE in line with national guidance (and in particular a fluid-resistant surgical mask) where close contact with other staff is unavoidable then this will not count as close contact.

6.30 The Test and Trace service has three levels of response:

- Level 2 and 3 are managed at a national level organised centrally on behalf of Department for Health and Social Care. These are call handlers who run through the set protocols for anyone who has been identified as a possible close contact of a confirmed positive case of COVID-19. It is thought that the majority of contacts will be relatively straightforward and be advised to self-isolate at home. However, there are some circumstances where additional skills and input is needed to follow up. If there is any level of complexity, for example if the person works in health or care setting then these cases will be referred to Level 1 of the test and trace system.
- Level 1 is the service provided by the Public Health England South West Health Protection Team. This team have also been bolstered by NHS returners and practitioners on secondment from the Local Authority Public Health Teams. To date we have 3 people from Public Health Dorset working in this role. This team provide more in-depth contact tracing and support to more complex settings or vulnerable individuals, such as within a school, hospital or care home setting.



6.31 The results from the test and trace service is also key data to help build our understanding out the picture of COVID-19 infections locally and will allow us to rapidly identify any increase in cases in any particular place or context. The table below shows how NHS Test and Trace will support outbreak management at different levels.

Level	Decision maker(s)	Co-ordination, advice and engagement	Support and Assurance
Individual setting	Individuals or bodies responsible for that setting (e.g., Head Teacher, restaurant owner)	• Public Health England (local Health Protection Teams) • Director of Public Health teams	***NHS Test and Trace Local Teams will liaise at all levels as needed and with relevant government departments, ministers and COBR***
BCP Council area	Decisions may be taken by the: • Chief Executive • Director of Public Health • Corporate Director (for Communities and Housing, Adults, or Children)	• COVID-19 Health Protection Board • Local Strategic Co-ordination Group • Local Outbreak Engagement Board (BCP Council Health and Wellbeing Board)	
Cross-boundary	*N/A – agreed cross-boundary decisions will be implemented at UTLA level*	• Dorset Local Resilience Forum (LRF)	

6.32 In a small proportion of cases it may be needed to actively follow up an individual if they have tested positive but have not made contact or provided the necessary information for the service but there is an increased possibility of harm e.g. if they are a care worker. In these types of circumstances, the COVID-19 Health Protection Board will identify an appropriate response, potentially through visits from colleagues such as Environmental Health Officers, Housing officers or Drugs and alcohol outreach workers. This will be dependent on the circumstances of the case or contact and action cards will be developed around common scenarios.

7 Prevention and Response Plans for Places and Communities

7.1 Prevention of COVID-19 and reducing the risk of developing more serious complications is a priority in this plan. We have been running campaigns to help people quit smoking, using the COVID pandemic as an incentive for change. Getting fitter by taking up physical activity and or losing weight through support from the LiveWell Dorset service is an effective way of countering some of the known risks from COVID-19, which can disproportionately affect people living with diabetes and other long-term conditions.

7.2 In line with national guidance we have identified a range of high-risk places where localised plans will be required for the prevention of COVID-19 transmission and the management of any such outbreaks. Settings are considered as 'high-risk' for a number of reasons, including: environments that limit people's ability to socially distance; activities that could inadvertently pose a greater risk of immediate or onward transmission; places that have a higher concentration of people who are vulnerable and/or susceptible to adverse outcomes of COVID-19 infection. We will continue to review the list of high-risk settings in BCP reflecting on:

- emerging evidence relating to risk
- emerging national guidance.
- in consideration of the phased lifting of national restrictions.

7.3 The following settings are currently considered contexts where there may be a higher-risk of transmission of COVID-19:

7.4 Hospitals (acute and community hospitals) Hospitals are perhaps the highest risk settings for transmission and outbreaks of COVID-19. This is due to them having higher concentrations of positive cases, together with staff working in close proximity to patients, heightening potential exposure to the virus during the course of treatment. The chances of adverse outcomes from the disease are also greater in patients whose health status may already be significantly compromised. The movement of staff and patients in and out of hospitals can also be linked with outbreaks in the wider community.

Primary and community healthcare settings

7.5 Community Healthcare settings should be considered higher risk, because symptomatic patients (more likely to COVID-19 positive) may seek medical support in this context. Similarly, these and other patients in these settings may have greater susceptibility to the disease.

Care homes

7.6 Outbreaks of COVID-19 in care homes are of great concern as, generally, residents are highly susceptible to the virus and outcomes of the disease amongst this group are very poor; this is particularly the case amongst older and/or frail residents with pre-existing clinical conditions. The nature of providing personal social care to multiple people, provides opportunity for transmission between staff and those being cared for,

both within a single care home and across others, where staff can work across several homes.

Houses of Multiple Occupation

7.7 The likelihood of transmission of the virus in Houses of Multiple Occupation (HMOs) may be greater than that in other types of housing due to closer proximity between residents and between households. The sharing of common areas and joint facilities is an additional risk factor.

Prisons

7.8 The key risk in prisons is large numbers of people in relatively confined spaces, sharing common areas and facilities. An outbreak of COVID-19 in a prison setting could affect many people in a short period of time, with knock on consequences for the provision of healthcare services. Staff could also be affected by an outbreak and it could become difficult to maintain normal regimes and the expected levels of security.

Homeless housing (temporary accommodation; long-term supported accommodation; approved premises – probation; rough sleepers)

7.9 Accommodation which houses people at risk of homelessness requires an additional focus as, like HMOs, residents may be living in closer proximity to one another and or share common areas/facilities. Some residents may also have chaotic lifestyles and/or have problems with drugs or alcohol. As a result, behavioural responses that mitigate transmission of the virus (e.g. social distancing or hygiene measures) could be significantly compromised. Residents may also have great pre-existing health needs. These types of accommodation also tend to be more temporary, so people are more transitional between settings, making transmission more difficult to track.

Gypsy and Traveller sites

7.10 Heightened risk may be associated with households living in more confined spaces, making social distancing and effective isolation measures more difficult. Additionally, there is evidence that some residents might be less likely to seek support from health services if they become unwell and this could increase the possibility of a disproportional impact from COVID-19 on these communities.

Park Homes

7.11 Whilst some park homes are large, many are not and there may be a heightened risk of transmission within households living in more confined space, as social distancing and effective isolation measures could be more difficult. There are a significant number of park homes in BCP, a high proportion of which are occupied by older residents, who are more vulnerable to adverse outcomes from the disease.

Ports and ships

7.12 There are two ports of entry in the BCP Council area, including Port of Poole and Bournemouth International Airport. Both are considered high risk because they are transport hubs through which volumes of people travel, potentially from countries that are also experiencing the coronavirus pandemic.

Agricultural/fishing and food processing plants

7.13 Outbreaks of COVID-19 have been associated with food processing plants possibly due to confined working conditions for numerous staff. Onward transmission of the virus through contamination of food products and/or packaging remains a concern, the impacts of which could be widespread.

Public transport (taxis, buses and trains)

7.14 Whilst specific circumstances vary somewhat, the key concern associated with all forms of public transport is that people's ability to socially-distance is likely to be compromised. There is also the potential risk of transmission of the virus from where people have physical contact with surfaces. It is very unlikely that contact tracing will be effective in picking up on potential transmission between unknown people using public transport, meaning prevention of transmission is the only realistic strategy for containing outbreaks in this context.

Schools and early years settings (including boarding and SEND schools).

7.15 Whilst evidence shows a reduced rate of transmission of COVID-19 between children and young people, schools and early years settings are still considered high-risk settings. This is because, children, particularly younger ones or those with impaired cognitive functioning, are less likely to understand and practice effective infection control measures. There are large numbers of individuals gathered in these settings, so even if rates of transmission are lower, there is still opportunity for an outbreak to develop with knock-on implications for the wider community. With shared accommodation and shared use of facilities, boarding schools provide an additional challenge.

Higher/further education settings – universities, colleges and language schools

7.16 As with schools, where large numbers of individuals gather and participate in activities together, there is a potential risk of COVID-19 outbreaks occurring. Where colleges provide accommodation for students, the additional risks associated with communal living and shared use of facilities will need to be taken into account.

Manufacturing / light industry

7.17 Depending on the types of processes involved, work in manufacturing and light industrial settings could result in higher risk of transmission between workers. Risk assessment will need to take into account the proximity of workers and the potential for transmission of the virus through physical contact with commonly shared items and/or equipment.

Military Camps and Training Facilities

7.18 Some elements of military operations and training may involve groups of people coming together and working in close proximity. Shared accommodation and use of facilities in military barracks, also means these are considered high risk settings.

As government restrictions lift, these will be additional high risk areas for planning:

Hospitality sector (e.g. hotels, holiday parks)

7.19 The hospitality sector makes up a significant part of the local economy. With potentially large numbers of people travelling to BCP from other areas and moving into temporary holiday accommodation locally, there is a clear concern about the potential for outbreaks. Holiday visitors may be less attuned to public health messaging and these settings provide challenges to the prevention of transmission as accommodation tends to be more concentrated often shared use of facilities.

Cafes, restaurants, pubs, clubs and bars

7.20 Many of these settings which serve food and drink rely upon the throughput of significant numbers of people, often within a relatively confined space. As lockdown-type restrictions are eased, many local businesses will be keen to restart and boost their activities and revenue wherever possible. Doing so whilst minimising the risk of transmission will be key to preventing future outbreaks. Again, managing outbreaks through contact tracing will be severely limited in these settings, where individuals are unlikely to know or be able to provide details of people with whom they have come into contact. Transmission via the handling of food and drink products is also possible.

Places of worship

7.21 Internationally there have been large outbreaks of COVID-19 linked with gatherings associated with collective worship. Local places of worship are therefore considered high-risk settings for transmission of COVID-19. The risk is mainly due to significant numbers of people gathering together in close proximity, often for a considerable period of time. Many local congregations include a high proportion of older people, who will be more vulnerable to poor outcomes if they become infected.

Indoor leisure facilities (sporting, fitness, theatres, cinemas)

7.22 These settings often involve groups of people gathering in enclosed spaces where social-distancing could be compromised. Whilst specific circumstances will vary, many indoor leisure facilities will constitute high-risk settings for this reason.

Planning actions relating to high-risk settings

7.23 A clear set of actions that incorporate both the proactive prevention of transmission of corona virus and the management of outbreaks is required for each of the high-risk settings described above. Where action plans have already been developed, a brief summary of these are set out in the next section. An overview of plans (including those yet to be fully developed) is set out in Appendix C together with contact details of the individuals tasked with their development. As plans and action cards are agreed for each high-risk setting, they will be added to the over-arching Local Outbreak Management Plan as additional resources under the toolkit section.

NHS Organisations

7.24 Our local hospital trusts, community trust and 6 primary care networks have done incredible work as part of our response to COVID-19 and are now facing the challenge

of restarting many mainstream NHS services that were paused. Action to tackle infections acquired in the NHS itself, whether staff, visitors or patients will be a key enabler to this. Within the south west, this is being managed using the NHSE Outbreak Management process and local NHS partners are reviewing and updating their internal outbreak management plans in line with the letter of 9 June **'Minimising nosocomial infections in the NHS'** to ensure:

- ongoing and consistent implementation of national infection prevention and control guidance,
- adhering to social distancing (2 metres) wherever possible, including in non-clinical areas
- from the 15 June, all NHS staff wear a surgical face mask when not in PPE or in a COVID-secure facility in line with the workplace definition set by the government.
- use additional available NHS testing capacity to routinely and strategically test asymptomatic frontline staff.
- turnaround all COVID-19 tests within 24 hours
- follow existing Public Health England guidance on defining and managing communicable disease outbreaks, with updated reporting arrangements
- From 15 June visitors and outpatients to hospital settings should wear a form of face covering to prevent the spread of infection from the wearer

Care homes

7.25 There are 158 care home settings registered with the CQC in BCP Council - this includes nursing homes, residential homes and learning disability homes. A number of outbreaks in care homes locally have already been identified and managed during the COVID-19 pandemic to date.

7.26 Extensive work has already been done on managing outbreaks in a care home setting and BCP Council has a Social Care Support Plan which gives detailed information on plans for infection control, PPE, workforce training and clinical support.

7.27 There is an agreed process for managing outbreaks locally to ensure that care homes are provided with the appropriate infection control support when an outbreak is identified and that there is oversight of the control measures put in place to contain the outbreak. This involves collaboration between the council and Dorset CCG, with advice from Public Health England where needed and close working with care home managers and staff.

7.28 There is also a locally agreed set of criteria so that there is system oversight and agreement that an outbreak has ended, and that any restrictions placed on a care home can be safely lifted. These criteria will be refined as further opportunities for improvement are identified. (Appendices)

7.29 All staff in care homes routinely complete infection protection and control training, and all have been offered the option of either face to face or virtual refresher training which specifically focuses on the effective use of PPE. The council and CCG are working together to undertake a quality assurance process to identify any homes that need additional support.

7.30 Most homes in the council area are now completing the capacity tracker daily. This allows them to report any issues with workforce capacity, access to PPE or symptomatic staff or residents.

7.31 A key development moving forwards will be to develop local arrangements to support testing within care homes more effectively at an early stage of an outbreak. The ability to identify infected staff and residents earlier, particularly where they are asymptomatic, would enhance the opportunities to prevent spread within a care setting.

Schools and Early Years settings

Preparation and information resources for Schools and early years settings

7.32 Many Schools and Early Years providers in BCP have been open throughout the COVID-19 pandemic, providing small classes for Keyworker children and those identified as vulnerable.

7.33 Public Health Dorset and BCP Council officers have worked closely with School Heads and Senior Leaders in settings to safely prepare for children returning to early years settings and schools in BCP on a phased return from the 1st June 2020.

7.34 The school and early years settings have been working on implementing national guidance from both Public Health England and the Department for Education to mitigate the risk posed by COVID-19. These key control measures include:

- Children are allocated to a bubble of no more than 15 children
- Rotas for classes and/or staff is discouraged
- Social distancing measures are established within the school buildings
- Use of outdoor spaces where possible for teaching and learning
- Increased emphasis on good hand and respiratory hygiene measures.
- A small amount of Personal Protective Equipment to be available to protect staff in the event of a child becoming symptomatic at school and requires care prior to collection by a parent or guardian.

7.35 The preparation and response to school outbreaks very much builds on the established processes which exists for support to schools from the Public Health England South West Health Protection Team. In preparation for any response to a COVID-19 related situation the following resources have been developed and distributed by the PHE team to Senior Leaders in each setting by email and through regular LA lead forums.

7.36 Public Health England South West Health Protection Team have provided:

- A powerpoint presentation on infection prevention and control.
- A flowchart reminding schools on what process needs to happen in response to a suspected case of COVID-19.
- A webinar to explain the COVID-19 guidelines for educational settings, presented to Headteachers and available as a recording online.

- In addition, weekly webinars are available for schools to dial into, every Tuesday, Wednesday and Thursday from 4pm, covering infection prevention principles and discussing scenarios to illustrate IPC. Registration using: https://www.eventbrite.co.uk/e/COVID-19-educational-settings-webinar-tickets-109457638744

Special Schools

7.37 Special schools have all the support as documented above which is available for schools, including from Public Health England and Local Authority teams. Recognising the additional and often complex needs of this cohort of children, additional work including a weekly Head Teacher forum, has supported these school communities to open safely to small numbers of children.

7.38 Special schools are very experienced in supporting children with considerable medical needs, however, the need to provide intimate and/or medical care for these children in school has posed additional challenges within a context of a rapidly developing understanding about COVID-19 as more information is gained about this disease. This is particularly important for any children or families who are in the shielded category.

7.39 There are often well-established links with the Paediatrics teams in the Acute trusts and many have dedicated nursing teams within the school itself and these staff have worked hard to support these children and families during the COVID-19 pandemic.

7.40 Where appropriate, school staff have also been trained in the use of appropriate Personal Protective Equipment (PPE) particularly around the small number of high-risk procedures such as Aerosol Generating Procedures.

The process for Outbreak Reporting and Outbreak Investigation

7.41 The Regional Health Protection Team of Public Health England South West have worked with the South West Health Protection network of Local Authority Public Health teams to agree a protocol for a joint response to support schools in the event of a COVID-19 related situation.


How to contact HPT V2.pdf


Educational and Childcare Settings Flo

7.42 It has been established that PHE will report both *Suspected* and *Confirmed* cases by email to the following people at Public Health Dorset:

- Sam Crowe – Director of Public Health, Public Health Dorset.
  Sam.crowe@dorsetcouncil.gov.uk
- Rachel Partridge – Assistant Director Public Health, Public Health Dorset.
  Rachel.partridge@dorsetcouncil.gov.uk (01305) 225880
- Joanne Wilson – Head of Programmes, Public Health Dorset.

Joanne.wilson@dorsetcouncil.gov.uk (01305) 225894

7.43 COVID-19 Case or Situation or Outbreak stakeholder Notifications are cascaded for information and action to the following officers with the Local Authority for awareness and potentially provide support to the headteacher where required:

- Judith Ramsden – Director of Children's Services
  judith.ramsden@bcpcouncil.gov.uk
- Julia Coleman - Service Manager School & Provider Standards & Support 0-19
  julia.coleman@bcpcouncil.gov.uk (01202) 458229
- Neil Goddard - Service Director, Quality and Commissioning
  neil.goddard@bcpcouncil.gov.uk (01202) 456136
- Julian Radcliffe - Service Director Inclusion and Family Services
  julian.radcliffe@bcpcouncil.gov.uk (01202) 451252

7.44 Public Health Dorset Communications team have also agreed to work with Public Health England Communications team to support any schools affected by an outbreak to deal with any media enquiries.

7.45 Public Health Dorset also commissions Dorset Healthcare to provide the Children and Young People's Public Health Service and as part of the agreed contract the service may be deployed by agreement to support the management of infectious diseases in the context of an outbreak:

- "The service would be an important partner in local arrangements for managing infectious disease outbreaks where additional screening or immunisation is part of the local response for children and/or young people, with additional resources agreed within local plans"

7.46 Resources could be scoped and mobilised as appropriate, with due consideration to any opportunity cost against providing core mandatory services. All Safeguarding responsibilities must and will be protected.

Future Planning

7.47 It is widely recognised, and the available evidence has been reviewed that a key impact on schools and early years settings will be Emotional Health and Wellbeing for:

- Children and Young People
- Parents
- Staff working in schools and settings including early years

7.48 Specifically, children and young people, who are in year groups which would ordinarily include a transition e.g.

- Early years to Primary
- Junior to Secondary
- Secondary to Further Education, Employment or Training

7.49 Partners working collaboratively to develop and deliver the local Emotional Health and Wellbeing Strategy and NHSE Local Transformation Plan have met to develop resources and support to prepare for any increase in wellbeing needs.

7.50 Children and Young People

- Mapped EHWB resources and services against the THRIVE model
- Actively promoted CHAT Health and KOOTH online/digital offers using social media.
- A sub-group has met to identify, share and develop appropriate approaches to supporting CYP through key transitions. There are online, virtual and face to face offers available in Dorset Council and Bournemouth, Christchurch and Poole Council localities.

7.51 Parents

- A single infographic for educational settings will guide parents to valuable resources to support CYP with their emotional health and wellbeing.

7.52 Staff working in Schools and other educational settings including Early Years

- Promoted and personalised to educational settings the Our Dorset Mental Health Offer presented in a one-page info-graphic
- A webinar on the 25th June 2020 at 10am, aimed at Head Teachers and SENCO's will remind staff of local services, including Public Health Services, CAMHS, Educational Psychology and Mental Health Support Teams in Schools and provide a panel style Question and Answer opportunity. The webinar will be recorded and available to staff to access in their own time.

***Surveillance* - COVID-19 Surveillance in children attending preschool, primary and secondary schools**

7.53 The National Infection Service is working with Public Health England to understand how the new coronavirus, SARS-CoV-2, affects children, teachers and other study in preschool, primary or secondary schools. They also want to know whether children can be infected with the virus without developing any symptoms. This information is important because it will help decide how to bring all the children and staff safely back to school.

7.54 Weekly nasal swabbing of children and staff will be undertaken over the course of 4-5 weeks (until the end of the academic year). Results will be provided to the parents and the child's GP should a positive result be concluded and advice to stay at home for 7 days, regardless of symptoms. The child can return to school after 7 days as long as they are well.

7.55 In Bournemouth, Christchurch and Poole Council a couple of schools have consented to take part in the sKid study.

7.56 Summer School Holidays and return to school in September 2020

7.57 In addition to the existing limited number of year groups and key workers who are attending school during the summer term, the planning will need to be in place for the

expansion to all school children from September. This Local Outbreak Management Plan will need to be reviewed in view of the circumstances and guidance which will be in place then.

7.58 There are also plans for the provision summer holiday programmes for some children. The planning for these will also need to factor in preparation, prevention and response to COVID-19.

8 Protecting and supporting vulnerable people

8.1 The BCP Council response to supporting the cohort of shielded residents, and those at risk or in need of help in general, since the start of lockdown has been highly impressive. The Council has played a key role in both managing call centres and orchestrating the crucial contributions from volunteers and voluntary/community sector organisations.

8.2 As part of this response we have reflected on how well we believe we have supported vulnerable groups at this time and have produced an Equalities Impact Assessment (EQIA) relating to the lockdown period. As the economic impacts of lockdown continue to become apparent, we are mindful of vulnerability emerging amongst groups of people who may previously have been in steady, sustained employment, so an ongoing approach to EQIA will be necessary, taking into account and adjusting for newly identified needs.

Supporting people who have been asked to self-isolate

8.3 We aim to support all residents required to isolate as a result of COVID-19; providing a population wide response tailored to support vulnerable groups.

8.4 Following confirmation of positive cases, internationally recognised evidence of what constitutes good practice in contact tracing for COVID-19, categorises the process into three key tasks/stages:

- *Case* investigation: Rapid contact with people who have tested positive to ensure they isolate, followed by an interview determining any significant contact they have had with others.
- Isolation advice: Contact tracers call each of those contacts asking them to isolate, then follow up frequently to make sure they are doing so.
- Care resource co-ordination: Care co-ordinators help people to solve problems that might prevent them from isolating effectively – e.g. finding an immediate place to stay, manging employment issues, how to get food etc.

8.5 This section of the plan is concerned with stages 2 and 3 above.

Isolation advice

8.6 Instructions to individuals on isolation is the primarily the responsibility of the national Test and Trace and Regional Public Health England teams, however local authorities and local NHS partners will act to reinforce key messages using local communications strategies and trusted local voices. This will include:

- Re-enforcing the importance of social distancing and other control measures
- Reminding the public of the importance of hand washing as our first line of defence;
- Requesting adherence to isolating when required, to stop the spread of infection; and
- Setting out the support available locally to support people required to isolate.

Care resource co-ordination

8.7 Gaining good compliance with requests for social isolation is critically important in effectively managing local outbreaks. Once more general lockdown restrictions are lifted, for practical reasons, individuals may find it more difficult isolate effectively. Our approach will utilise the Council call centre as a focal point for offering support. This will involve having 'strengths-based' conversations, supporting individuals to overcome practical difficulties associated with isolating, themselves, and co-ordinating local services and deploying resources through communities as needed. Assuming the relevant information can be shared by national bodies (Public Health England and the Test and Trace service), local call centres will be able initiate contact with those required to isolate and also go on to follow up with them regularly should that be required. To enable people to effectively isolate the call centre could need to support people with:

- Access to food and medicines
- Income support if required
- Advice on employment related issues
- Housing/accommodation issues
- Sustaining care for any dependents (children or adults)
- Social support
- Ongoing monitoring arrangements.

8.8 Effective isolation will be more difficult for some, and where someone faces multiple challenges, an individual volunteer may be assigned to them, in a similar way that which has been done for some shielded residents. It is envisaged that this could be an important offer for more vulnerable groups, in particular.

8.9 The COVID-19 'lockdown' period has seen highly effective partnership arrangements across statutory and voluntary sectors deliver extensive support to those in our community. The structures, policies and procedures that have been developed during the lockdown period will be utilised and developed further in support of managing local outbreaks. As a result of recent work to accelerate an asset-based approach to mapping local services, facilities and groups, there is now an even better network of voluntary and community partners which could play an important role in the communication of key messages to local communities in support of managing any future outbreaks.

Supporting more vulnerable groups

8.10 Independent from the high-risk settings described in section 6, it is also important to recognise that certain groups of people are, relatively speaking, more vulnerable to

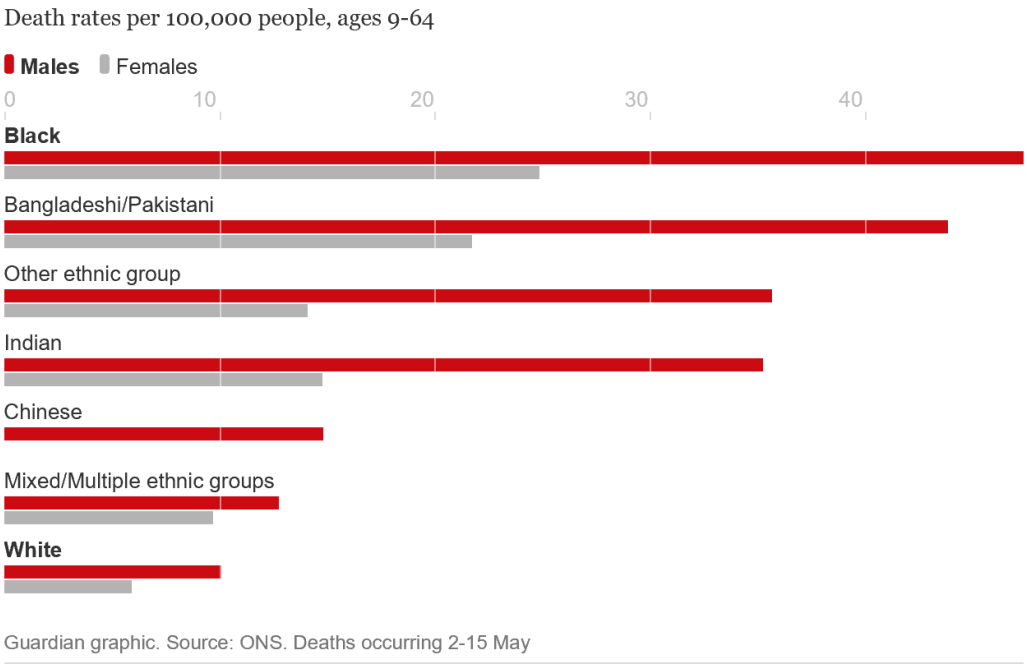
poor outcomes associated with COVID-19, either as a direct result of the virus itself, or linked to the significant social and economic fallout from the pandemic. In this section we seek to describe, what the evidence shows, to be the more vulnerable groups. Whilst it may not be possible to mitigate the disproportional impacts of COVID-19 for these groups, it is important to bare vulnerability in mind when preparing preventive actions and outbreak management plans.

Clinically vulnerable

8.11 In instigating the national shielding programme, the government recognised the potential impact of COVID-19 on people with pre-existing health conditions. As mentioned, local authorities have taken a central role in supporting people who have been shielded (self-isolating for a long period of time) during the course of lockdown. As restrictions are increasingly lifted, people who are high-risk due to their pre-existing health status need to be considered in responses to any outbreak. It might be that actions to shield this group need to be stepped up again, depending on the extent of local COVID-19 infection locally in future. As has been the case over recent weeks, GPs should be centrally involved in identifying their patients who are particularly at risk and the data pertaining to this group shared with NHS and Local Authorities in order that they can continue to support those who may be shielding.

Age, gender and ethnicity

8.12 A clear pattern of vulnerability has emerged as the COVID-19 pandemic has gone on. Absolute risk of adverse outcomes from the disease increases with age (approximately doubling every 7 years); so, the risks of poor outcomes for those infected with the virus in older age groups are very significant. Gender is also a factor; whilst prevalence between men and women is the same, men with COVID-19 are more at risk from worse outcomes and death, independent of age. Risk profiles amongst black and minority ethnic groups also demonstrate heightened risk with the most recent study showing that black males in England and Wales are over four times more likely to die after contracting COVID-19 than white males.



8.13 These demographic factors affecting risk in local populations need to be considered as part of local plans, and should, for example, be taken into account when making decisions about standing up or standing down public health measures to limit spread of the disease in local populations. They also link with the emerging action planning for the prevention and management of outbreaks in high risk settings.

Economically vulnerable

8.14 Analysis of ONS data shows people living in more deprived areas experience COVID-19 mortality rates more than double of those living in less deprived areas. Generally, mortality rates are normally higher in more deprived areas, but COVID-19 appears to be increasing this effect. Furthermore, the economic downturn associated with the pandemic is likely to have an even greater negative affect on people who are less well-off, further exacerbating health and social inequalities over time. Again, social deprivation is a factor that will considered in determining emerging risks from the virus in our local communities, along with any subsequent actions. Actions which seek to mitigate against widening inequalities should also be central to parallel workstreams in the local system, focused on staged recovery from impacts of the pandemic in BCP.

Communication and engagement

8.15 Ongoing local campaigns will be needed to address the issues and plans set out in this section, focusing on additional communications developed for those required to isolate, and key accessible messaging for groups more vulnerable to any future outbreaks. We will need to localise materials and prepare for communicating effectively with:

- Those for whom English is not their first language
- For those with learning disabilities

- For those with sensory impairment

8.16 Engagement with local communities will entail close working links with, amongst others, Dorset Healthwatch, local engagement champions/network groups, voluntary and community sector organisations. The role of ward councillors will also be very important in this regard.

8.17 Communications around outbreak controls and our planning will need to be clear and transparent. It will seek to reassure our residents, staff, business community and visitors. We will provide regular messaging on what the local data is telling us, what that means in BCP and how that will influence plans.

9 Resources

9.1 Allocations to Upper Tier Councils to support developing outbreak management plans were announced on 10 June. BCP Council received non-recurrent funding of £1.8m, based on the formula used to determine Public Health Grant amounts. The responsibility for resource allocation lies with the Chief Executive.

9.2 The resources required to support this Local Outbreak Management Plan fall into three broad areas:

- prevention
- monitoring / surveillance and
- outbreak response including surge capacity.

9.3 Predicting resource requirements will be easier for the first two of these. Many of the tasks required to support prevention and monitoring / surveillance overlap considerably with core business for partners and the current COVID-19 response arrangements also support these. However, as partners across the system begin to step back up non-COVID-19 work or services, we will need to ensure that we are able to maintain this focus. To date we have identified the following resources as being additionally required to support prevention and monitoring / surveillance:

- Additional communications capacity, to support public engagement boards (Health and Wellbeing Boards) and in specific outbreak scenarios
- Epidemiology specialist modelling capacity
- Public health practitioner capacity – as backfill for support provided to Public Health England Tier 1 contact tracing
- Training resources – for example providing online access to infection prevention and control training
- Translation / equalities dimensions – reasonable adjustments we might need to make for reaching and working with communities of people with protected characteristics.

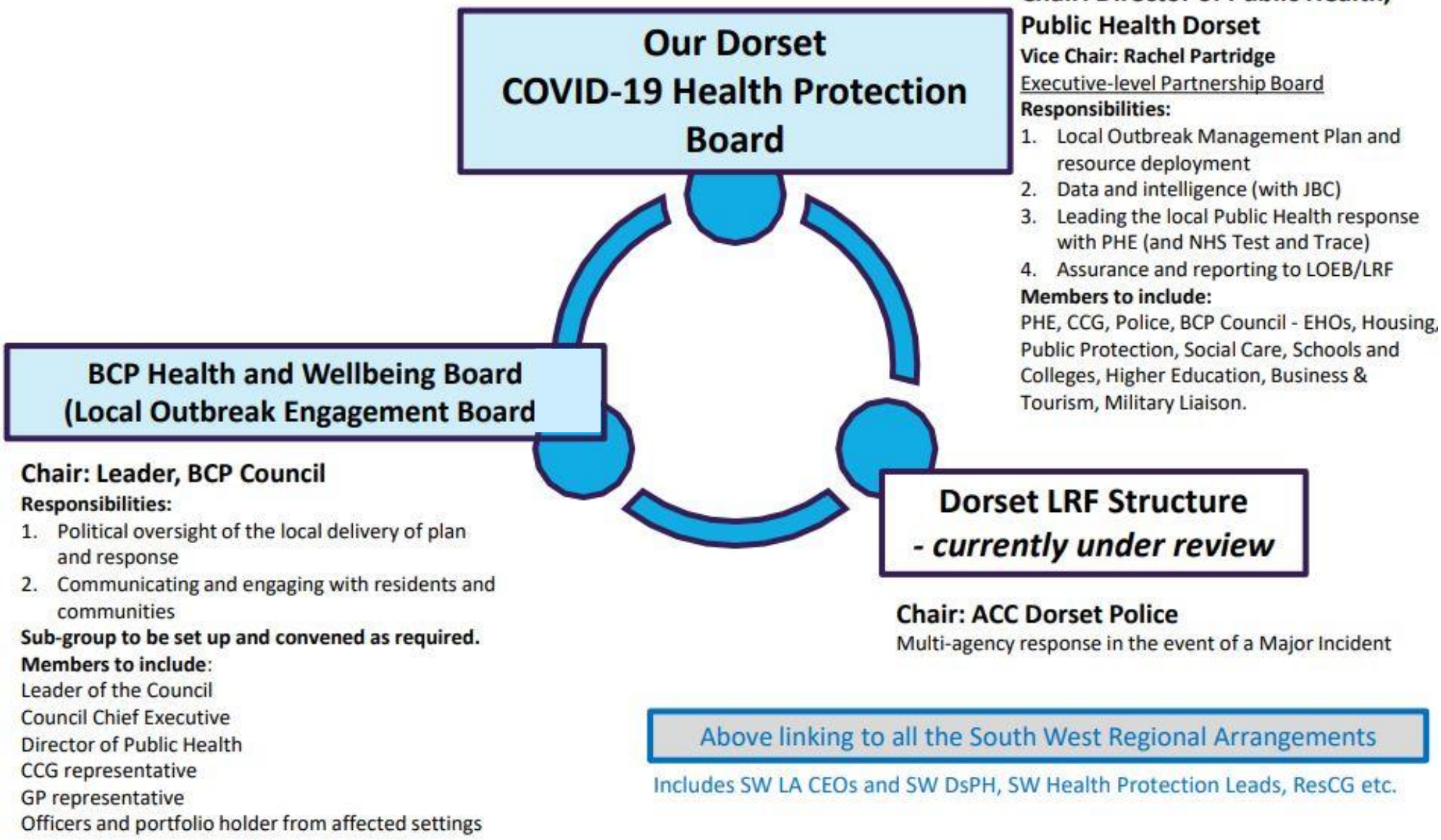
9.4 Outbreak response will require additional surge capacity at very short notice. While the bulk of contact tracing will be handled by NHS Test and Trace, and regional health protection teams, there is often the need for additional support. This could include support around infection prevention and control, communications and engagement,

following up in person with people who have been asked to self-isolate, including ensuring any basic needs are met. The scale and frequency of this is unpredictable. We can anticipate needing to draw on Council helpline capacity and volunteer support at short notice. Resource requirements will likely include:

- Surge capacity for core functions: EHO, call centre staff
- Support / infrastructure for volunteering / community shield.

9.5 As this local plan is developed alongside any further guidance on the conditions of the new 'Test and Trace Service support grants', resourcing plans will be developed for sign off by BCP Council chief executive – who has oversight and responsibility for how the allocation is used.

APPENDIX A: Draft Governance Arrangements



Appendix B: Local data flows and reporting as at 19/6/20

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Manual or scheduled data updates for integration into local dashboards			Death returns from local Registrars	ONS Mortality released CQC deaths in care homes		Twitter analysis update Mobility analysis update	
Dashboard updates - Metadata for items within the dashboards includes date of most recent update.	DiiS dashboard: • The majority of the DiiS data is updated daily through automated feeds from local Hospital Trusts and/or GP systems. • Connects to the national care home tracker system, providers are expected to update entries weekly as a minimum • Some data (community mortality) relies on CQC data release as outlined above - updated on the day of the release.						
				Dorset Surveillance and Monitoring (SAM) dashboard		Dorset Surveillance and Monitoring (SAM) dashboard	
Outputs and reporting		SitRep report from DiiS to Health & Care Silver	System briefing by email	SitRep report from DiiS to Health & Care Silver Previous 2 weeks EpiCell briefings at Excess Deaths Advisory Group (every fortnight) This week's EpiCell briefing drafted (week 1 data, week 2 model)	System briefing by email This week's EpiCell briefing at Strategic Co-ordinating Group	SitRep report from DiiS to Health & Care Silver	System briefing by email This week's EpiCell briefing at Health & Care Silver Group and at Tactical Co-ordinating Group

APPENDIX C: South West Framework matrix (names and contacts, not necessarily discussed and agreed as yet)

Sector	Section		Lead Group	Key contact	Partners
Hospitals		Acute		Rachel Partridge/Nicky Cleave	
		Community		Rachel Partridge/Nicky Cleave	
Primary and community healthcare settings				Rachel Partridge/Nicky Cleave	
Care Homes			Social Care Subgroup	Rachel Partridge/Nicky Cleave	Local Authority Adult Social Care Care Sector Representatives Dorset Healthcare Primary care Networks CCG
Schools/early years			Schools Forum and Headteacher Network	Jo Wilson	Schools, Dorset HealthCare, Local Authority
Universities, colleges and language schools (including private)			PHE Universities Group	Jo Wilson	PHE, University
Children and Young People		*Schools and early years settings (including boarding and SEND schools*		Jo Wilson	Local Authority CCG Dorset Healthcare

					Schools
Military Camps and Training Facilities				Paul Iggulden	
High risk settings		*Prisons*	Regional Prison meeting	Rachel Thorne Rachel Partridge/Stuart Burley	PHE, HMP, NHSE
		Public Transport		Local Authority Transport Team	Transport Providers Local Authority
		Large Manufacturing plants		Vicki Fearne	Local Authority Economic Development Team. Local Enterprise Partnership (Dorset LEP) Chambers of Commerce? Business Improvement Districts
		LOCAL DISCUSSION: Agricultural work/work in seafood industry heavily reliant on migrant workforce in dormitory style accommodation		Regulatory Services	NFU/ Dorset AONB FWAG/ Regulatory Services Health & Safety Executive? DC County Farms
		Airports/Ports	Ports and harbours LRF subgroup	Caroline Fair Tamsin Horsler	Local Authority Regulatory Service.

					Harbourmaster Port Authorities Border Force
		Hospitality sector (including Caravan and camping sites, hotels and beaches, etc)		Chris Ricketts / Rachel Partridge and EHOs	Local Authority Regulatory Services
		Park Homes		Chris Ricketts / Rachel Partridge and EHOs	
		Cafes, restaurants, pubs, clubs and bars		Chris Ricketts / Rachel Partridge and EHOs	
		Places of worship		Chris Ricketts / Rachel Partridge and EHOs	
		Indoor leisure facilities (sporting, fitness, theatres, cinemas)		Chris Ricketts / Rachel Partridge and EHOs	
Vulnerable Individuals and groups		***Homeless housing (temporary accommodation; long-term supported accommodation; approved premises – probation; rough sleepers)***	LRF Safe and well group	Housing Team/Adult Social care Will Haydock	Local Authority Community and Voluntary sector Primary care Network CCG
		Houses of Multiple Occupation (HMOs)		Will Haydock	
		Refugees and Asylum seekers	LRF Safe and well group	Housing Team/Adult Social care	Local Authority Community and Voluntary sector Primary care Network CCG

		Gypsy, Traveller and Roma	LRF Safe and well group	Susan McAdie	Local Authority Community and Voluntary sector Primary care Network CCG
		Disabled people and carers	Social Care subgroup		Local Authority Community and Voluntary sector Primary care Network CCG
		People with LD and autism	Social Care subgroup Mental Health and	Mark Harris	Local Authority Community and Voluntary sector Primary care Network CCG
		Mental Health Service users	Mental Health subgroup	Mark Harris	Local Authority Community and Voluntary sector Primary care Network CCG
		Older People			
		People with underlying health conditions	Community Shield		Local Authority Community and Voluntary sector Primary care Network CCG

		Health and Care Staff	Health and Care Silver	Vanessa Read	NHS Trusts, CCG, Primary Care, Social Care, workforce group
High risk communities and neighbourhoods		*BAME Communities*		Paul Iggulden/Susan McAdie	

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