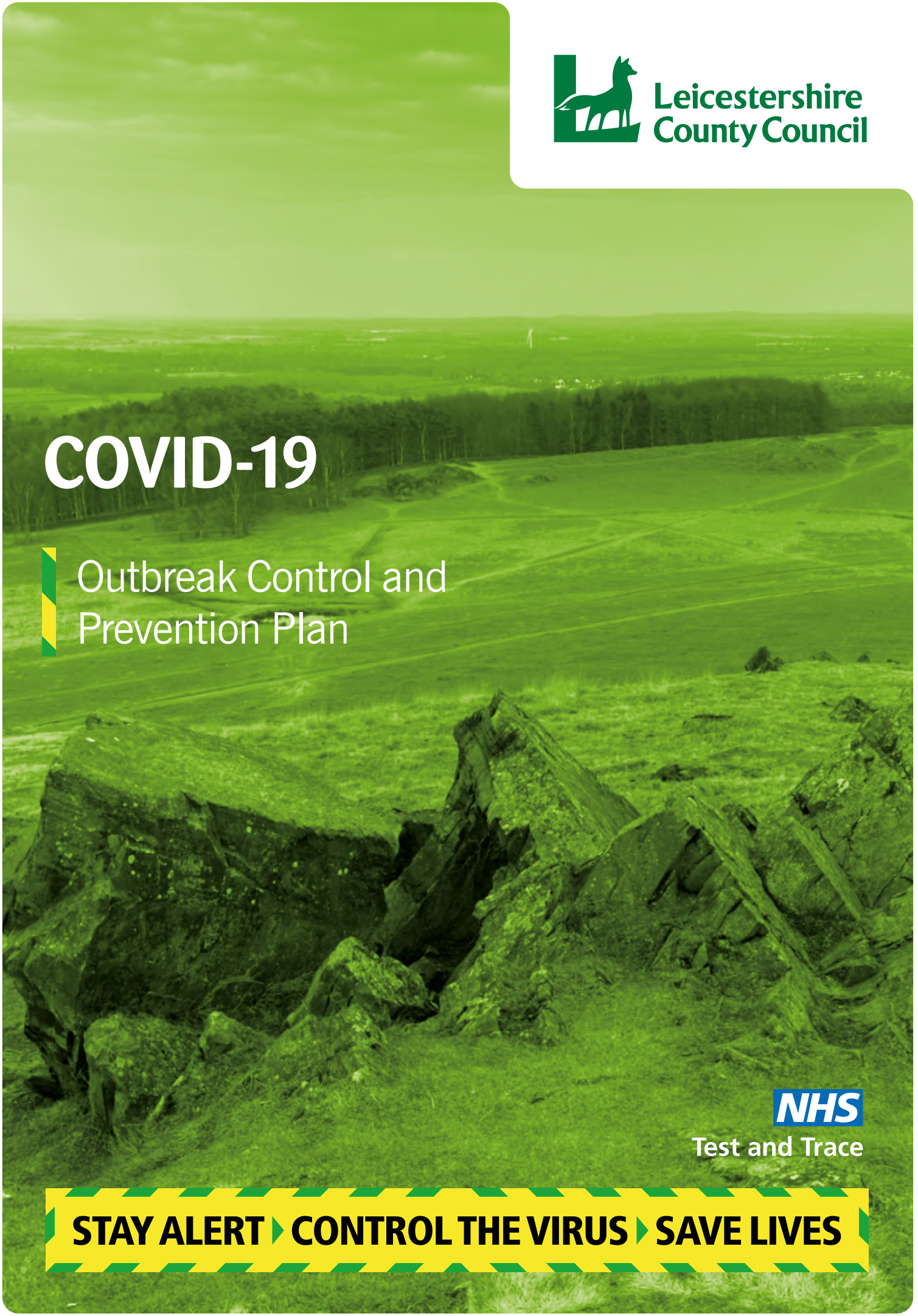


Leicestershire County Council

COVID-19

Outbreak Control and Prevention Plan

NHS Test and Trace

STAY ALERT ▸ CONTROL THE VIRUS ▸ SAVE LIVES

Contents

1. Purpose

This plan is intended to enable agencies in Leicestershire to prevent, manage, reduce and suppress outbreaks of COVID-19 infection across the County. This plan sets out the arrangements for surveillance of and response to local outbreaks and infection rates. The plan identifies aims, objectives and the appropriate governance and responsibilities for each of those. It details the support Public Health will provide to organisations in a range of settings and outlines what those organisations can do to support themselves in the event of an outbreak.

On 22nd May 2020 Government announced that as part of its national strategy to reduce infection from COVID-19 it would expect every area in England to create a local Outbreak Plan. Government expects that local plans, led by the Director of Public Health, will be produced by the end of June 2020. This Local Outbreak Plan builds on existing health protection plans and response mechanisms and puts in place measures to contain any outbreak and protect the public's health. The Director of Public Health (DPH) is responsible for defining the measures required to do this.

2. Aim of plan

The aim of the Local Outbreak Plan is to protect the health of the population of Leicestershire from COVID-19. This will be done through the following objectives:

- Preventing the spread of COVID-19 and associated disease
- Early identification and proactive management of local outbreaks
- Co-ordination of capabilities across agencies and stakeholders
- To assure the public and stakeholders that this is being effectively delivered

3. Roles and Responsibilities

Developing and delivering this outbreak plan requires the involvement and engagement of partners and key stakeholders at strategic and operational levels in line with the governance structures (see diagram below and governance section).

Diagram 1: Multi-agency work in outbreak management

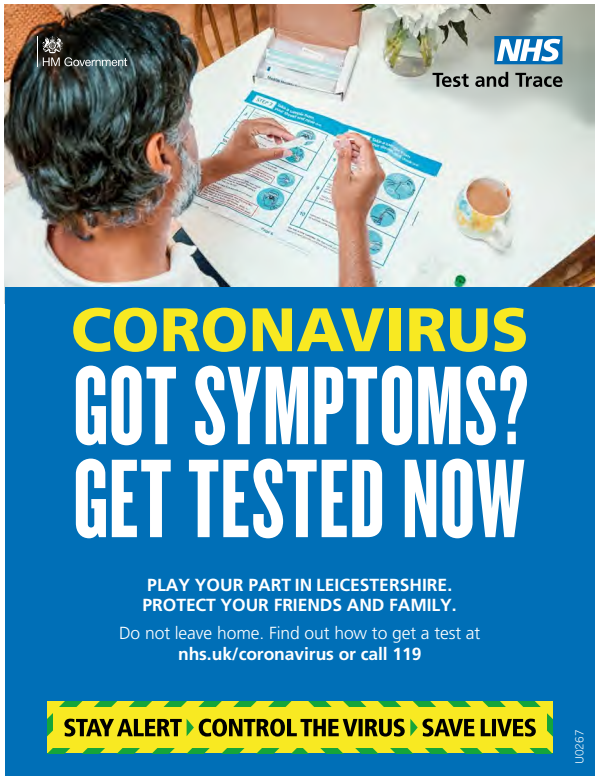
Communications

Good communication is key during an outbreak or incident. Leicestershire County Council communications team, together with Public Health England (PHE) will undertake the lead role for communications when responding to COVID-19 outbreaks or incidents locally.

Direct communication with cases/patients during the incident will be undertaken by Public Health England in the first instance with support and surge capacity being offered by teams, under the direction of the Director of Public Health.

Leicestershire County Council communications team, working with the Public Health team will support the infection control and prevention work with targeted messaging and community engagement, working with partners across the system including in primary care networks and the voluntary sector. They will use a variety of tools including mainstream and community media, social media, local newsletters and workplace communication channels.

The proposed communications plan can be found in appendix 1.



4. Managing Outbreaks

Public Health England (PHE) will remain the first point of contact for the notification of positive cases and outbreaks. A standard operating procedure has been agreed regionally with PHE detailing the link between PHE and Local Authority Public Health Teams **(Appendix 1)**.

Outbreak control notification and action

Single case notification

PHE will inform the on-call public health consultant of any single cases related to settings under theme 1 (Care Homes and Schools) and 2 (high risk places, locations and communities) of the control plan. This notification will also feed into the infection control service inbox, and in the medium term into the proposed health protection team. Additionally, two way liaison would enable local Public Health to alert PHE of any single case issues that PHE may be unaware of.

New outbreaks in settings

PHE will remain the first point of call for notification of outbreaks and will be responsible for undertaking initial investigation and actions. COVID-19 is a notifiable disease and cases must be reported to PHE on 0344 225 4524.

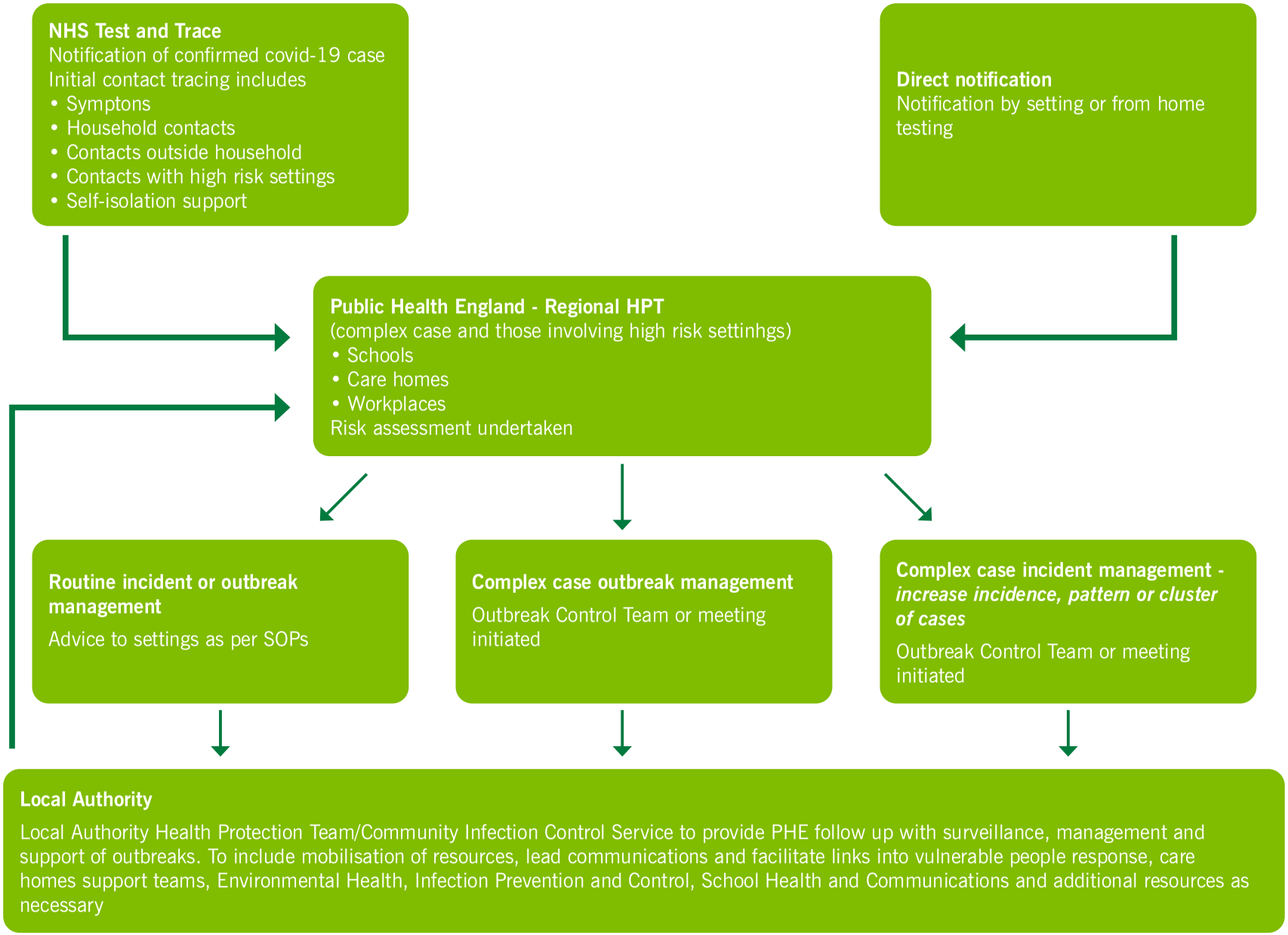
There is an expectation that PHE will inform the DPH/on call Public Health consultant of outbreaks, as happens currently through the HP Zone database, and agree any further actions that may be needed in relation to Infection Prevention and Control (IPC), testing, contact tracing or communications. This information will also feed into the existing infection control email inbox and service.

New outbreaks in communities

Experience has shown that community outbreaks may not be notified by PHE East Midlands but may come about through local knowledge or national analysis. In this case, the on-call consultant and DPH will ensure PHE East Midlands are informed and will lead outbreak management.

A health protection consultant on call rota is being established within LCC PH, covering LCC and RCC, as the single point of contact for out of hours (OOH) PHE liaison/outbreak notification alongside a dedicated email address (infection@leics.gov.uk). For ongoing advice, the on-call Public Health consultant number is 0116 305 1525. In operational conditions it is expected that PHE and the on-call consultant will assume autonomous control of an outbreak situation in contact with the DPH and lead the establishment and leadership of an Incident Management Team (IMT).

Diagram 2: Outbreak management process flowchart



The incident lead/outbreak control team will exercise the appropriate measures at their disposal including:

- Communications
- Community engagement
- Deployment of testing
- Enhanced surveillance and contact tracing as deemed necessary
- Any legal powers as deemed necessary under relevant Public Health Acts and the Coronavirus Act 2020 and any other powers that may be conferred in due course. The legal powers available are listed under **appendix 3**.

The membership of a core outbreak control team shall comprise:

- Incident lead (Consultant in Public Health and/or DPH)
- PHE Consultant in Communicable Disease Control (CCDC)
- Comms
- Testing lead/link, other members as required;
- District council (EHO, communications, engagement)
- PH Analyst
- NHSE&I
- CCG/Primary care network/primary care representative
- Other County Council colleagues (chief executives, corpora, children and families, adults and communities, environment and transport)
- Other LRF partners organisations (e.g. Police)

A specimen agenda for use by the incident lead is included in the Full Operational Plan appendices 3.

Contacting outbreak settings

In the event of an outbreak or situations requiring a setting to be contacted, existing on call mechanisms will be utilised by PHE and the on-call consultants either through LCC Senior managers (07730 583238) for theme 1, educational settings and care settings or the LRF emergency management number (0116 305 6101 or 07786 198 283) for theme 2, and other high-risk settings.

Ongoing surveillance and management

In addition to managing outbreaks as above a daily sit rep will be delivered by PHE (via CCDC or nominee) as required covering current outbreaks and new outbreaks. The battle rhythm will be determined by the number of outbreaks and may require daily meetings of a core group (DPH, Health Protection Consultant lead, consultant on call, PHE) within the County Council. This will consider if any additional actions are needed above and beyond that agreed by PHE/consultant on call and escalate any issues as necessary to the Health Protection Board. Outbreak management will be in line with the nationally developed action cards (details of action cards included in Full Operational Plan).

If there are a fewer number of outbreaks then the daily sit rep meeting will not be required and the meeting of the Health Protection Board will suffice.

IPC/Health Protection Service

In the short term, the existing IPC outbreak service (for care homes) will record monitoring and surveillance data in relation to all outbreaks including schools and high-risk situations, settings and places this will include:

- Monitor and respond to IPC email inbox notifications/enquiries on working days
- Oversee numbers of outbreaks and day to day management
- Provide regular situational report of number of outbreaks in different settings

Further outbreak actions for the Council will be picked up by the existing Public health team with input from the current IPC service within the operational and governance structures described in section 8. Public Health consultants within the existing team, with responsibility for particular settings, such as schools, will support outbreak management and oversight in these areas.

In the medium term (and as soon as possible) we plan to establish, a new health protection team to provide a COVID-19 outbreak response service. This team will provide a sustainable, longer term, health protection function within the Council, recognising that the local outbreak plan requires a health protection response that is a new responsibility for Local Authority Public Health. This new team will be based on the model of our existing IPC care home service but will respond to outbreaks in other settings. This team will operate during working hours to monitor and respond to outbreaks as required, alongside the consultant on call.

Proposed new Health Protection Team

Providing a follow up outbreak response to PHE in a range of settings in addition to care homes is not sustainable within the current Public Health team capacity. Hence the planned development of a new health protection team (as indicated above) to be part of the Public Health Department.

Additional resource requirements have been identified including IPC specialist and PH health protection capacity as well as managerial and administrative resources to ensure that this outbreak response is sustainable over a 12 month period.

5. Control and Prevention

Controlling the spread of COVID 19 is the first step to preventing an outbreak. These actions will include:

- **Environmental and structural measures:** Putting physical measures in place to support social distancing in public spaces and workplaces.
- **Enhanced hygiene / cleaning:** It is important for people to continue to regularly wash their hands and follow good respiratory hygiene practices.
- A**dvice, guidance and training:** Ensuring we use the media and communications to inform and message the public to promote adherence to the guidance and to support behaviours that reduce the spread of COVID 19.
- **Engagement:** Ongoing engagement through local communities and district colleagues, faith groups and the community and voluntary sector to promote guidance, model 'good' behaviours in communities and constructively engage with those people that are not complying with guidance. Primary care networks and/or primary care staff could also be used for engagement and messaging, with GPs seen as respected figures in their local communities
- **Resources and staffing:** Proactively supporting settings (and particularly high risk settings including care homes) with accurate and timely advice and ensuring there are sufficient resources to implement infection control measures.
- **Data:** Use of epidemiological data alongside surveillance and monitoring data, gathered in relation to outbreaks, to flag up potential 'hot spots' for early targeting and intervention (See section 7).
- **Enforcement:** The use of such measures available under relevant legislation to enforce social distancing, local movement etc.

Prevention

Alongside outbreak management as set out below a specific workstream of the operational plan will focus on prevention. This will involve targeted comms utilising local and community radio, social media and print media alongside engagement with community leaders and champions.

Support will be offered to schools, care homes, workplaces and other high-risk settings to enable them to proactively 'do the right thing' on social distancing, hand hygiene and physical barriers. Additionally, settings will receive the national action cards (when available) so they are aware of the actions necessary in the event of an outbreak.

The 'offer' from the core Public Health Team will support settings in understanding the actions they need to take if they experience an outbreak.

Sections a. and b. provide further information on outbreak management.

Each outbreak response will require:

- Settings to be identified and contactable: agreement reached to access LRF key organisational and setting contacts within the system to access contacts in the event of an outbreak, where the existing service does not already hold this information.
- Outbreak management plans in place for all types of setting – This will be in line with the nationally developed action cards **(details of action cards included in Full Operational Plan).**
- COVID-specific mechanisms (e.g. outbreak control groups) in place – outbreak control groups/IMT will be mobilised, where required under the leadership of the DPH/Lead consultant in collaboration with PHE and other stakeholders and in line with leadership and governance structures described below in section 8.
- Support with communications including messaging to the public and management of media interest.

General Outbreak Management Process

The outbreak management process for all outbreaks following notification from PHE currently includes the following:

Receive notification from PHE:

- Record details of outbreak site including: key contact phone and email on spreadsheet
- Record details of PHE action taken to date and key PHE contact for the outbreak
- Record follow up action requested by PHE
- Notify lead PH consultant
- Record no. of positive cases
- Record date of initial symptoms/test date of last case (self isolating)
- Record no. self isolating

Contact outbreak setting (if appropriate):

- Follow checklist and relevant action card
- Checklist to include: car sharing; staggered breaks; one way systems; social distancing; handwashing; cleaning of surfaces; PPE; frequently touched surfaces etc.
- Identify and record any particular issues or concerns
- Escalate to establish IMT if significant concerns
- Provide guidance and support and offer follow up information.
- Provide IPC email inbox address for further help and advice.
- Request that any additional positive cases be notified to IPC email inbox.
- Agree routine monitoring calls from PH LA every 7 days (or more where appropriate)
- Close outbreak 28 days after date of initial symptoms or test date of last positive case.

a) Planning for local outbreaks in care facilities and educational and early years settings.

Care Facilities: Local Outbreak response:

A Care Home outbreak IPC response helpline is already in place and fully operational across Leicestershire, Leicester City and Rutland (LLR) on a 7 days per week basis. This is led by Leicestershire County Council; working in collaboration with Leicester City Council; Rutland County Council and PHE.

Following PHE initial assessment and advice, follow up outbreak monitoring, surveillance and oversight is handed over to the LLR IPC service.

A robust system is in place to provide regular monitoring calls to care homes with an active outbreak. Support and IPC advice is provided until closure of outbreak (28 days after date of initial symptoms or test date of last positive case). Where care homes require additional help and support, issues/concerns are escalated to IPC specialist and/or PHE.

In the medium term it is intended to develop this model further and incorporate it into the planned health protection team which will deal with COVID-19 outbreak responses across a number of settings.

As part of the existing care home model we also make proactive calls to care homes providing preventative advice and support to those homes without outbreaks. The intention is to continue this service, if possible, and to include it as part of the wider planned health protection team for outbreaks in other settings.

Care home action cards covering the required responses to specific care home scenarios and required responses are included in the Full Operational Plan. These action cards will be used to inform operational responses to outbreaks.

Action cards will also be used to inform care homes and other care facilities on how best to prevent outbreaks in their setting; and how to prepare for an outbreak.

Care facilities - contacting

Latest Care Quality Commission (CQC) data indicates that there are 183 Residential and Nursing Homes in Leicestershire offering 5,206 beds. Local intelligence indicates that six of the homes registered with the CQC are inactive and the actual number of beds available is 5,015.

The Council currently commissions 1,535 permanent placements for adults aged over 65 and whilst Clinical Commissioning Groups (CCGs) and other Local Authorities also commission places in Leicestershire, this indicates that there is a sizable self-funder market in the county.

The Adults and Communities Department have a contact list of all contracted and uncontracted providers across the range of care settings. Those settings are communicated with regularly by the Department and the A&C departments Business Support team facilitates this regular access for the IPC service.

An extensive list of contact details related to care homes is already in place as part of the existing service and is available to the on-call consultant but can also be enabled through the LCC Senior on call manager.

The Care Quality Commission (CQC) web-site also provides updated contact information for Care Homes, Nursing Homes and Extra Care Housing.

Schools: Local Outbreak Response - A process has been established whereby schools are asked to notify the Local Authority when they have a positive COVID-19 case, in addition to notifying PHE. When the Local Authority have been notified, this information is then be fed into the Public Health consultant on call/IPC service as well. This information will be recorded and monitored alongside and as part of the existing 'care home' monitoring and surveillance system. In the medium term this information will be fed into the proposed health protection team.

PHE already notify public health of any COVID-19 outbreaks in schools. These are recorded on the existing 'care home' monitoring and surveillance system.

An agreement has been reached, in principle, that PHE will handover the follow up, day to day management of schools outbreaks (where they no longer have the capacity to manage these).

In these instances a Local Authority PH consultant will have oversight of these outbreaks in terms of health protection/IPC input with support from an IPC nurse.

Action cards for schools and other children and young people's settings will be used to inform any outbreak response in these settings (action cards included in the Full Operational Plan).

Action cards will also be used to inform schools and other children and young people's settings on how best to prevent outbreaks; and how to prepare for an outbreak.

Educational and early years settings - contacting

Early Years Settings.

There are over 800 child care settings in Leicestershire providing care for babies and children up to 4 years of age. Some of the providers also provide wrap around care for children pre and post the school day and over the school holiday period.

Contact detail for all settings can be founds here:
https://tableau.leics.gov.uk/#/workbooks/7968/views

For out of hours contact details contact can be made through the On Call Senior Management system.

Schools

There are around 280 state schools in Leicestershire and a large number of independent schools who provide education for children across the whole age range. In addition to this there are 6 Special Schools operating in Leicestershire. Contact details for all schools can be found at:
https://tableau.leics.gov.uk/#/workbooks/7968/views

For out of hours contact details contact can be made through the On Call Senior Management system.

Further Education Colleges

There are 6 FE colleges in Leicestershire. Details can be found at:
https://tableau.leics.gov.uk/#/workbooks/7968/views

Children's Residential Providers

There are a large number of residential children's homes in Leicestershire who provide residential placements for children both from within Leicestershire and outside of Leicestershire. Contact details for the providers can be found at: https://tableau.leics.gov.uk/#/workbooks/7968/views

For out of hours contact details contact can be made through the On Call Senior Management system.

b) Other high-risk locations, workplaces and communities: Local Outbreak Response

Outbreak response oversight will be provided by the local authority consultant lead supported by the DPH and PHE as described in previous sections as follows:

Outbreaks in High Risk Settings

PHE provide initial advice and support in the event of an outbreak in a high risk setting. The LA PH follow up response will aim to be asap and by the next working day, if possible.

Actions to include:

- Identify if the outbreak setting is located within the area covered by Leicestershire County Council, Rutland County Council or Leicester City Council.
- If the outbreak setting is located within the area covered by Leicester City Council, forward to PH consultant Health Protection lead at Leicester City Council to make aware and to provide appropriate follow up for these outbreaks.
- If the outbreak setting is located within the area covered by Leicestershire County Council or Rutland County Council, record details on the non-care homes spread sheet template on share point system, including contact details, numbers of positive cases and numbers self-isolating.
  - If the setting is a school, nursery or children and young people's setting notify the appropriate lead consultant.
  - If the setting is a workplace, forward to Health Protection lead consultant.
  - If the setting is a hostel (or similar setting), notify the appropriate lead consultant.
- For all other settings, notify the Public Health IPC nurse, and inform the Health Protection lead consultant and the Director of Public Health.
- Contact with setting – The lead consultant with IPC nurse support will make contact with the outbreak setting, if appropriate. They will assess the situation and provide any input necessary. PHE may also be contacted to provide further information about the outbreak.
- PH LA contact with outbreak settings will include understanding any particular concerns or issues in the setting that require further input in key areas e.g. social distancing, PPE, car sharing. A checklist will be used and/or the relevant operational action cards (action cards included in the Full Operational Plan)) to ensure that key areas are discussed.
- Any actions identified to be followed up and logged on the non-care homes spreadsheet template on sharepoint.
- Where there are significant concerns, consider establishing an OCT/IMT with support from PHE in line with governance/escalation processes.

The proposed Health protection team will provide additional support, when in place (in the short term this will be provided by existing IPC arrangements).

The outbreak response for each situation, setting or place will be based on specified action cards (included in the Full Operational Plan) in line with operational and governance structures. The lead PH consultant will be responsible for providing oversight and identifying the need for further epidemiological assessment in collaboration with PHE and the DPH where required.

Proactive, preventative aspects of this work in relation to specific outbreak situations will be developed. Escalation procedures and wider governance structures will be utilised by the lead PH consultant where significant further public health action is required in outbreak management. For high risk settings, the knowledge and resources of district authorities (notably EHO's) will form an important part of the IMT.

High Risk Settings – contacting

Districts to be approached to provide single response re: contacts with high risk sites, where details not already held by the service. This will be facilitated via LRF structures, and during 'out of hours' through senior management on call rotas.

LLR prepared emergency management on call will provide the operational contact to a number of settings supplemented by district arrangements.

LLR Prepared in hours and out of hours contact details have identified and can contact NHS facilities, key transport including East Midlands Airport, train stations, bus stations, and detention centres (in liaison with the Police).

Work is ongoing with district councils to establish a list of identified places and contact details in relation to tourist attractions, workplaces and travel accommodation. This will be shared with LLR Prepared, subject to a check on data governance provisions, and will be able to be accessed through the LLR Prepared on call number.

Places of worship can be contacted through LLR Prepared working with the diocese.

Migrant worker dormitories are currently a gap in our awareness.

Homeless shelters – a single response from district councils is also being explored to determine the best way of contacting Homeless Shelters, where required. This will include routes through LRF Structures.

Community Based Outbreaks

In addition to the consideration of high risk settings and situations it will be important to be able to respond in a timely manner to 'hot spots' in particular communities or geographical areas.

The DPH in collaboration with other members of the public health team and PHE will continue to monitor and assess the epidemiological data and outbreak data to be in a position to respond and intervene early.

In such an event:

- An IMT would be convened in line with the Terms of reference (Draft TOR included in the Full Operational Plan)
- There would be rapid development and implementation of IMT actions,
- Oversight would be maintained by leadership and governance structures as outlined in this section 8.

Actions would include:

- Further data analysis and epidemiological assessment
- Deployment of targeted testing capacity in the area affected
- Media and communications
- Community and sector engagement including on the ground engagement, such as with primary care networks and/or primary care settings
- Exercising of any necessary legal powers

6. Testing

Testing in the context of this outbreak plan refers to antigen testing. Antigen testing is carried by taking a nasal and throat swab. The purpose of testing is to identify whether a person is **currently infected** with COVID-19.

The UK Government Testing Strategy has 5 pillars, of which, Pillar 1 and Pillar 2 are the two most relevant to local contact tracing and outbreak control:

- **Pillar 1**. NHS swab testing – this focuses primarily on key workers and outbreak response and in Leicestershire is coordinated via University Hospitals of Leicester.
- **Pillar 2**. Nationally coordinated commercial swab testing at Regional Test Centres (RTCs), Mobile Testing Units (MTUs) and home self-test kits – this provision is for all members of the public including those in the Pillar 1 category.

The main aims of developing a local testing local response are:

- To ensure that anyone with symptoms of COVID-19 can be tested quickly to find out if they have the virus.
- To provide rapid testing results to support the investigation of local outbreaks where necessary.
- To provide mass testing in the event of an outbreak.

Current infrastructure for COVID-19 antigen testing

The Leicester, Leicestershire and Rutland COVID-19 Testing Cell provides strategic oversight, and operational co-ordination of the local testing framework. A combination of regional and local testing infrastructure is currently in place.

Regional/National Testing Infrastructure

- **Regional testing sites:** drive-through testing is available at Birstall Park and Ride. This site forms part of the national testing programme, with testing available to anyone booking a test using the national testing portal. The site is usually operational from 8am-8pm and has capacity to undertake 840 tests a day but this could be increased to 1,300 if required. This would need agreement with DHSC.

- **Mobile testing sites:** 2 Mobile Testing Units (increasing to 3 on 13th July) that are run by the military and that offer drive through testing to symptomatic individuals. A timetable of approved sites is in place with the MTU remaining at each site for 3-4 days. Each MTU has capacity to undertake 300 tests a day.

- **Whole care home testing:** is available via a dedicated national care home testing portal, with swabs delivered directly to the care home and returned via courier service.

- **Home testing:** A postal service for swabs to be sent to individual homes. Homes test kits can be requested via the national testing portal.

Local Testing Infrastructure

- Derbyshire Health United (DHU) provides an outbreak response testing service to a range of settings. The service is currently mobilised on instruction by the Public Health England East Midlands Health Protection Team.

- Laboratory testing capacity provided by the University Hospitals of Leicester (UHL) as part of Pillar 1 testing. UHL has capacity to analyse 500 swabs a day at a turnaround of 24 hours.

Outbreak Response Testing

Public Health England (PHE) East Midlands will remain the first point of call for notification of outbreaks and will be responsible for undertaking initial investigation and actions. This includes mobilising Derbyshire Health United (DHU) to undertake testing of symptomatic individuals at any high-risk setting e.g. schools, care homes, homeless shelters, workplaces etc. The Local Authority Public Health Team will have access to DHU to undertake further testing at high-risk settings when the need arises. DHU's target deployment is within 24 hours of receipt of notification. DHU will obtain required samples and convey them to University Hospitals of Leicester (UHL) within 6 hours.

UHL has capacity to analyse 500 swabs a day at a turnaround of 24 hours. Over that volume, support can be requested from the East Midlands Pathology Network if turnaround time of 24 hours is required. All results from swab tests will be returned to DHU and passed on to the local public health team. UHL/DHU will also notify PHE of positive test results.

DHU is also able to respond to situations where mass testing is required in a particular setting, for example, a prolonged outbreak where testing of all individuals (symptomatic and asymptomatic) is required. DHU have a team of external colleagues that can be called upon in situations such as this. Where DHU does not have capacity, the existing LRF Testing Cell is well placed to coordinate and deploy local testing capacity. This will

be supported by regional mobile testing unit (MTU) capacity deployed by the Regional Coordinating Group with input from the Director of Public Health. There is also an opportunity to consider mutual aid arrangements with neighbouring authorities should the need arise for greater testing capacity.

In rare situations where the above options are at maximum capacity, testing of symptomatic individuals will be arranged through the national Pillar 2 portal: www.gov.uk/guidance/coronavirus-covid-19-getting-tested

Testing in high risk areas (geographical or population groups)

At present, there are 2 military run Mobile Testing Units (MTUs) that operate across Leicester City, Leicestershire and Rutland to provide geographically accessible testing to symptomatic residents (a third MTU will be available from 13th July). Each MTU has capacity to undertake 300 tests per day. A timetable of approved sites is in place with each MTU remaining at each site for 3-4 days. The existing LRF Testing Cell is well placed to coordinate and deploy this Mobile Testing Unit to a specific geographical location if intelligence identifies a 'COVID-19 hotspot' area. As the local Mobile Testing Unit is linked to the national Pillar 2 digital booking portal, it would be difficult to make last minute changes without disrupting existing bookings.. In situations where rapid deployment is required, the next point of call will be the regional mobile testing unit (MTU) deployed by the Regional Coordinating Group with input from the Director of Public Health (further detail included in the Full Operational Plan Appendices)

Testing of specific key-worker groups

While the primary aim of mobile testing is being able to test symptomatic people in the community, there may be incidences where an MTU will need to cater to a specific need – for example an identified group of key workers in an organisation that has reached critical mass of employees who are self-isolating with COVID-19 symptoms. In this event, it would be preferable to find the means of directly contacting the group to be tested to alert them to the site information while keeping the site off the national digital booking portal, thereby ensuring that the test slots are only available for the group being tested. The most appropriate resource to deploy in this situation will be DHU. The alternative being the regional mobile testing unit (MTU) deployed by the Regional Coordinating Group with input from the Director of Public Health

Testing of vulnerable groups

Testing of vulnerable groups in a particular setting (e.g. homeless shelter) can be arranged via DHU. DHU can also drop off test kits to a particular location or undertake blanket testing of a particular group if a site for testing is available. We are currently exploring the option to commission a specific provision for testing of vulnerable individuals to mirror the setup in Leicester City via Inclusion Healthcare. The proposed service will be required to work closely with our existing offer to vulnerable individuals, including each district community hub, Local Area Coordinators, First Contact Plus and the Falcon Centre.

Examples of local scenarios and testing options

- Based on the current COVID-19 positivity rate of 7% among care home residents and 3% among care home staff in the County, and based on the largest care home within the County (which has 136 beds and employs approximately 160 staff), in an outbreak situation, DHU & UHL will have capacity to conduct Pillar 1 testing in the following situations:

  - Testing of symptomatic care home residents only – equates to 10 tests.

  - Testing of symptomatic care home residents and staff only – equates to a total of 15 tests

  - Testing of all care home residents (symptomatic and asymptomatic) – equates to a maximum of 136 tests

  - Testing of all staff (symptomatic and asymptomatic) – equates to a maximum of 160 tests

  - Testing of all staff and resident (symptomatic and asymptomatic) – equates to a maximum of 300 tests

  In situations where whole care home testing is required for several care homes within a particular geographic patch, and where demand exceeds local capacity, DHU can conduct testing of all residents, while staff can access testing via the MTU or via home test kits.

- Where a localised outbreak is identified in a particular geographical area, a combination of Pillar 1 and Pillar 2 testing can be activated using DHU/UHL to focus on particular settings, and several MTUs strategically located at approved sites across the geographical patch. In a situation where all testing options are deployed to respond to an outbreak, there is an opportunity to conduct approximately 1,500 tests per day.

- Where opportunistic testing is required among homeless individuals, DHU is well placed to conduct testing at the local homeless shelter which provides accommodation for up to 30 individuals and drop-in sessions for a wider cohort of individuals (including those at risk of homelessness) with on average, 450 accessing the drop in every year. The local Pillar 1 testing capacity would also allow for testing of staff at the local shelter.

7. Contact tracing in complex settings

It is the view of Public Health England that they have sufficient contact tracing capacity to service the estimated number of outbreaks in the East Midlands. However, the Council has available surge capacity through two different levels if Public Health England run out of capacity for whatever reason.

In the short term the existing IPC Care Home response is manned by staff who could be redeployed, subject to training, to assist with contact tracing. The staff have acquired relevant transferable skills through their involvement in monitoring outbreaks within care homes.

However, as part of the planned new Health Protection team, that is being stood up, as soon as possible, we will have a permanent response team in place alongside an expanded service for First Contact Plus to deal with contact tracing and outbreak responses

Additionally, Environmental Health Officers can be called upon to assist contact tracing if needed via a 'call down' agreement with districts. This provides a further level of capacity resilience, and also can be used in complex situations where contact tracing might be more difficult or complicated, given the professional background of EHO's.

8. Supporting the Vulnerable

This plan seeks to support the vulnerable and/or those that need to self-isolate with no other source of support. We know that the mid-2019 population for Leicestershire was 706,155, with just over 50% of the population being made up of females.

The population is slightly older than the national average with 20.5% over the age of 65 compared to 18.4% in England. 16.8% of the population are under 15. The quinary age band with the biggest population is 50-54 years old which make up 7.5% of the total population.

Based on the 2011 census the majority of the county population (91.0%) belong to White ethnic groups, (including White Irish). The next largest ethnic group in Leicestershire is Asian (6.3%), followed by the Mixed or Multiple Ethnic Group (1.7%) and Black ethnic groups (0.6%). Only 0.1% of the population come from traveller ethnic groups with 47 recognised traveller sites in the county.

According to the 2011 Census, 11.4% of the population in Leicestershire live in a one-person household. Extrapolating this percentage to the latest population figures suggests 80,521 residents in Leicestershire lived alone in 2019.

Looking at disability the 2011 census found 16.2% of the county population reported having a limiting long-term illness this would equate to around 105,423 people. This is significantly lower than the national proportion of 17.6%.

Homelessness is lower in the county than the national average with a rate of 1.6 statutory homeless households per 1,000 households seen in 2017/18. This is equivalent to 465 households in the county.

There is a strong infrastructure within Leicestershire that incorporates a multi-agency approach to supporting vulnerable people. There are specific arrangements in place to support with food delivery through the national network of food distribution for those individuals that are shielding as well as local arrangements in place to support all other individuals that require support. There is also a medicine delivery system that is supported by local pharmacy and volunteer groups. These processes are set out below:

- Food distribution network setup that supports people that are self-isolating. Community Hubs are the main mechanism for supporting people with food or other types of support they need. The capacity in this network has been expanded using volunteers.

- The Medicine Delivery structure exists using community pharmacy as the central point of contact for individuals that need support. The pharmacy distribution network has been bolstered by the volunteer network and specially trained drivers to deliver bulk medication.

- Extensive volunteer support network sitting alongside the NHS GoodSAM application for the council to access as required for additional capacity.

Individuals that are self-isolating and need other support such as check and chat, befriending, help in the home or access to support services will be supported by the existing prevention infrastructure in Public Health, First Contact Plus and Local Area Coordination. First Contact plus can use its digital interface to receive self-referral or professional referral which then instigates a triage process. The outcome of the triage process results in onward referral to agencies that can support individuals in their home. This service could also be proactive by contacting people who have been asked to self-isolate in the same way it does with those that are shielded.

Priority groups such as BAME communities, Carers, traveller communities and the homeless will be supported by the Local Area Coordination programme where workers are based in the community and can support at a local level to ensure individuals are getting the right support for their circumstances.

9. Surveillance, Data and Epidemiology

Communicable disease surveillance involves the monitoring of the frequency and distribution of disease, as well as the human impact including hospital admissions and deaths.

Surveillance involves gathering a wide variety of data about a disease from a range of sources to provide a picture of emerging trends, hotspots and the groups of people who are being most affected or at risk. An overview of sources of data is shown below:

Diagram 3: Data sources informing surveillance and monitoring

Within our approach to outbreak control data management happens at two broad levels:

1) Data on local outbreaks that details information on cases identified and their management plans through to aggregated reported to partners.

2) Integration of data from multiple sources to generate local outbreak intelligence reporting.

a) Local outbreak data management

An application will be sourced that supports the local management of outbreaks. Data on positive test results will be imported or inputted into the application, alongside contextual information about contacts, implicated settings or processes, connecting cases in person, time and/or place. The application will support the development of action plans in response to cases, document the assignment of mitigation and prevention activities and provide real-time reports to support local incident management decision making.

On an operational basis Public Health consider exceedance reports available data on pillar 1 and 2 tests and ONS data on deaths to examine deaths and identify trends. This is supplemented by analysis of outbreak notifications and soft intelligence to consider any possible linkages or areas of concern either geographic or within communities of interest.

Data Integration

Locally, the LLR Data Cell has transformed the LLR COVID-19 Business Intelligence landscape and has built on the wealth of available data to support the development of usable insight/intelligence within the health economy.

The LLR COVID-19 Data Cell have attempted to replicate the recently introduced national COVID-19 Alert System. This alert system is updated weekly & shared with the Health Economy Strategic Group.

To replicate the national COVID-19 Alert System, it has been necessary to identify the key metrics and triggers that would guide decisions on where LLR currently sits on the Alert System. The LLR COVID-19 Data Cell identified the following as the key measures:

- Community Transmission Rates
- UHL & LPT Admissions
- LLR Cases, Deaths & Excess Deaths
- Operational Capacity (Bed capacity-all types)
- Care Home Capacity & Incidences (Domiciliary Care Input also)
- Testing Data (Pillar 1 and Pillar 2 data)
- Resourcing availability (Dialysis, PPE, O2, Reagents etc)
- National Triggers & NHSE/I Guidance Compliance
- Workforce availability (Staff Absence)
- Potential Population Harm

To support the new LLR COVID-19 Alert System, a weekly meeting takes place through a local 'SAGE' to review the available data and make a recommendation on the available information. The LLR SAGE group is comprised of strategic, data & operational leads from:

- Public Health,
- UHL & LPT providers,
- Primary Care,
- Social Care

The purpose of this group is to review the data available to LLR & make a recommendation on what level of the COVID-19 Alert System LLR currently sits on.

Key to this meeting is the acknowledgement of the national position (to avoid the potential for mixed system messaging) when making any key recommendations. -It is important to note that the new LLR COVID-19 alert system will be the view of the new LLR COVID-19 MDT SAGE (who will be guided by the available evidence).

The alert levels are described below:

Description	Level	Actions
Risk of local authority healthcare services being overwhelmed	**5**	All elective services should be suspended and all non-urgent face to face contact suspended
Local authority area transmission is high or raising exponentially Threshold R-Rate or local admission	**4**	
Virus is in general circulation across local authority area	**3** **Split below**	Phased restoration & transfer to new normal (with Cancer & Urgent Elective activity taking place)
Number of cases & transmission in the local authority area is low	**2**	Full implementation of new normal (based on the 10 agreed LLR principles)
COVID-19 is no longer present in the local authority area	**1**	

		Restoration/Recovery of those services, pathways or interventions classified by the local authority COVID-19 Cells as:
3 Split into three sub-levels	A	Red
	B	Amber
	C	Green

A review process for data with associated trigger points are outlined in the table below:

Trigger	**Threshold for review**
Community Transmission Rates	3 days of negative or positive growth
UHL & LPT Admissions	3 days of negative or positive growth
Cases, Deaths & Excess Deaths	7 days of negative or positive growth
Operational Capacity (Bed capacity-all types)	1 days of negative or positive growth
Care Home Capacity & Incidences (Domiciliary Care Input also)	3 days of negative or positive growth
Testing Data (Pilot Test, Trac & Trace Data)	3 days of negative or positive growth
Resourcing availability (Pharmacy, PPE, O2, Reagents etc)	7 days of negative or positive growth
National Triggers & NHSE/I Guidance Compliance	7 days of negative or positive growth
Workforce availability (Staff Absence)	3 days of negative or positive growth
Potential Population Harm	TBC
Population Movement	N/A

The COVID-19 tactical cells and UHL/LPT are currently grouping their Restoration/Recovery interventions/services into a Red, Amber & Green category system, with each category being implemented based on where LLR sits on the level 3 sub categories.

10. Governance and Structure

This plan is based on the guiding principles document from the Association of Directors of Public Health (ADPH) outlining the purpose of plans, the legal powers on which the plan is constructed and sets out principles for governance. **(Appendix 4.)**

Accountability for the management of outbreaks of OCIVD19 and the control of SARS COV-2 rests with the Director of Public Health and the County Council. These governance arrangements include:

1. COVID-19 Outbreak Planning Board- Responsible for the oversight of local outbreak control plans and outbreak management by Directors of Public Health.
2. Political Oversight Board- Provide political ownership and public-facing engagement and communication for outbreak response.

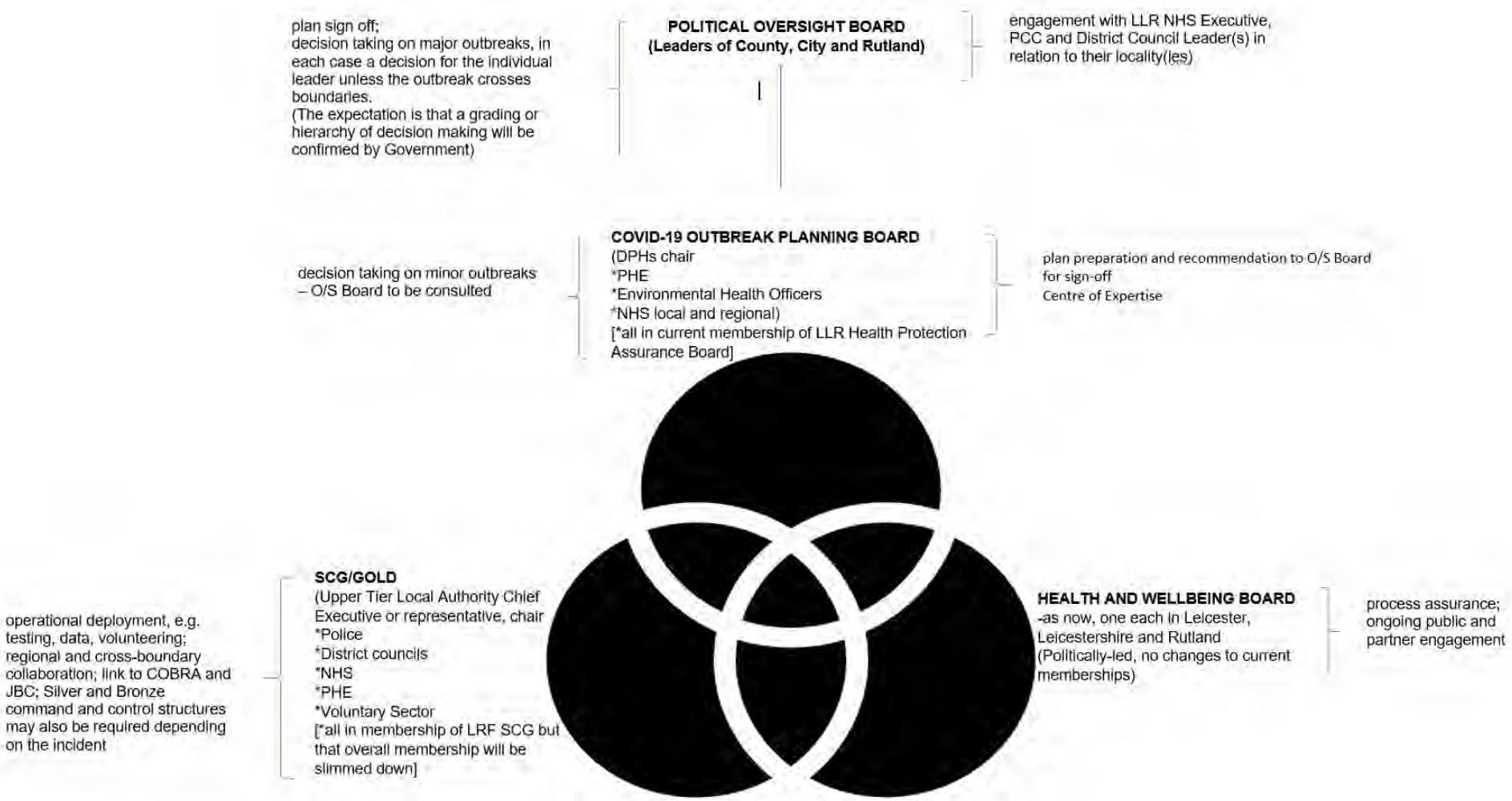
The Political oversight board

The political oversight board across Leicestershire, Leicester City and Rutland will act as a decision-making board in the event of increasing cases and outbreaks of COVID19.

The COVID19 Outbreak Planning Board

- The COVID Health Protection Board will seek to protect the health of the population of Leicestershire, Leicester City and Rutland by;
- Providing oversight of the outbreak management plan and communications plan
- Seek assurance of the response to outbreak and incidents
- Ensure oversight of data sources to support early identification and proactive management
- Ensure effective communication with stakeholders and the public
- Ensure effective links to wider system response including Local Resilience Forum and Sustainable Transformation Partnership
- Provide the specialist analysis of the local situation and local expert advice.
- Identify and escalate risk to Health and Wellbeing Board
- The Board will formally report to the Local Engagement Boards of both County and City. The Board will also report directly to the Health and Wellbeing Board and Local Resilience Forum.

Diagram 4: Governance Structure



Note

The governance structure may adapt to experience of increases in Covid-19 cases. At this stage, communication is seen as a responsibility which applies at decision-making, operational deployment and engagement levels.

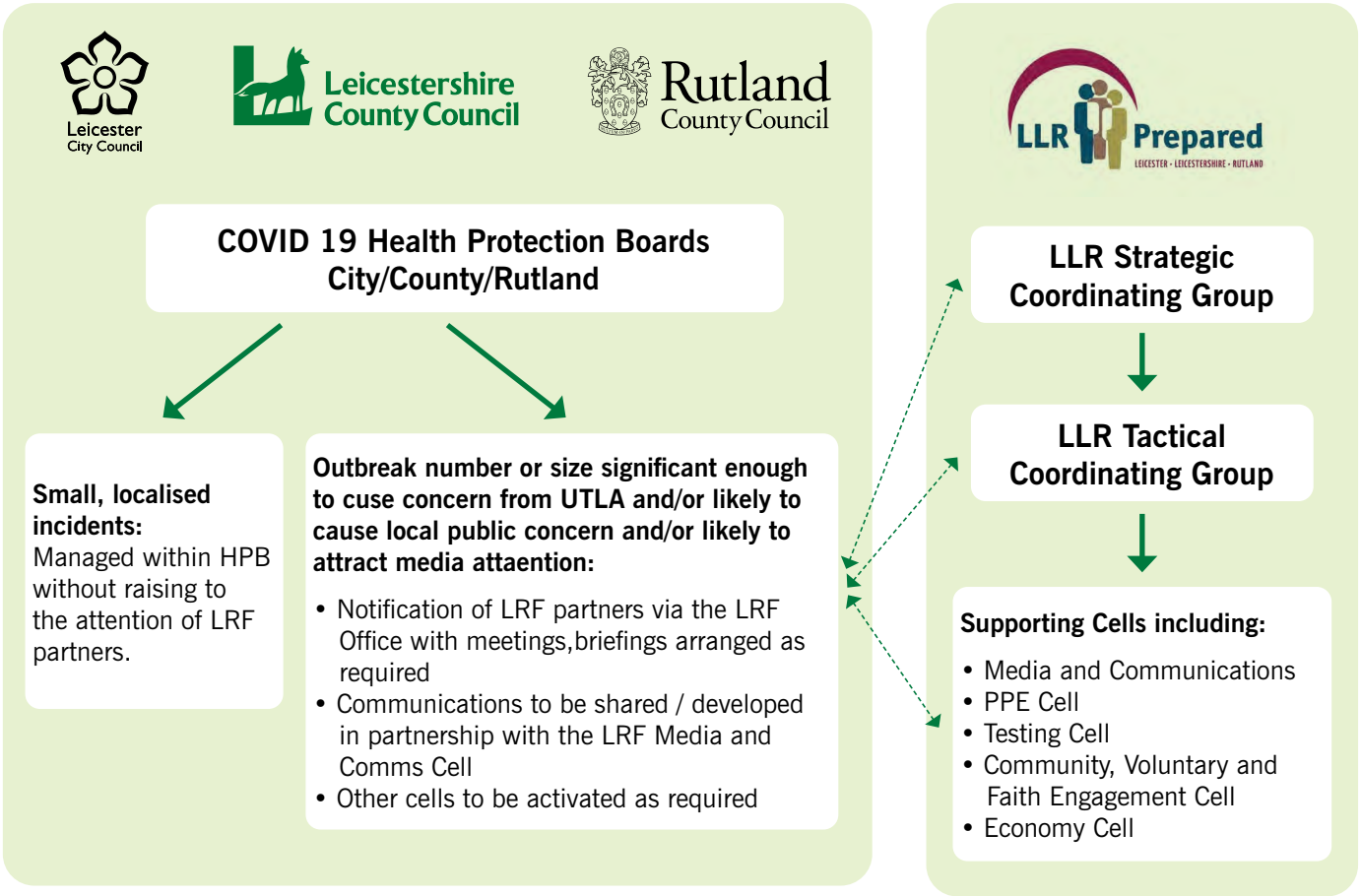
The terms of reference for the Health Protection Board are available at Appendix 4.

The LRF role

If outbreaks are in sufficient number or a size significant enough to cause concern from the Council and/or likely to cause local public concern and/or likely to attract media attention then LLR Prepared partners will be notified via the emergency management office with meetings/briefings arranged as required. At this level communications will be shared and/or developed in partnership with the Media and Comms Cell. It is also likely that other cells (potentially including the PPE cell, the Faith Cell, the Volunteering cell and the Testing cell may be activated as required.

A schematic of the relationship is shown below:

Diagram 5: Relationship between the LRF



Appendix 1

Local outbreak communications plan

Appendix 2

Standard Operating Procedure between Leicestershire County Council and Public Health England

Appendix 3

Summary of available legal powers

Appendix 4

Guiding Principles

Appendix 5

Health Protection Board Terms of reference