Local Outbreak (COVID-19) Control Plan

TO ACTIVATE THIS PLAN, GO TO SECTION 7.2

All organisations should ensure that if printed copies of this document are being used, the latest version is obtained from the Kent Resilience Team or Resilience Direct.

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**Issue & Review Register**

<table>
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<tr>
<th>Summary of changes</th>
<th>Issue number &amp; date</th>
<th>Approved by</th>
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<tr>
<td>Draft with headings &amp; introductions</td>
<td>v.0.1 31/05/2020</td>
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<tr>
<td>Various notes and Schools Section Added</td>
<td>v.0.2 03/06/2020</td>
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<tr>
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<td>v.0.3 05/06/2020</td>
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<tr>
<td>Updated draft incorporating comments and contributions from Colin Thompson (CT) + Wendy Jeffreys (WJ)</td>
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<tr>
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<tr>
<td>Final draft incorporating comments and contributions from AD + WJ + JW + SO + SB + ASC + AJ + SS + RP + BC + MC</td>
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<td>v.1.0 28/06/2020</td>
<td>JW + ASC + RP</td>
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<td>v.2.0 20/07/2020</td>
<td>JW + ASC + RP</td>
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<td>v.2.2 25/08/2020</td>
<td>N/A</td>
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<td>RP</td>
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<td>BAME</td>
<td>Black Asian &amp; Minority Ethnic Groups</td>
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<td>CAG</td>
<td>Confidentiality Advisory Group</td>
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<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CTAS</td>
<td>Contact Tracing Advisory Service</td>
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<td>DHSC</td>
<td>The Department of Health and Social Care</td>
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<td>DPH</td>
<td>Directors of Public Health</td>
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<td>EHO</td>
<td>Environmental Health Officer</td>
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<td>EPPR</td>
<td>Emergency Prevention, Preparedness and Response Team (SE regions, NHS England)</td>
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<td>GDPR</td>
<td>General Data Protection Regulations</td>
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<td>GP</td>
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<td>JBC</td>
<td>Joint Biosecurity Centre</td>
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<td>KCC</td>
<td>Kent County Council</td>
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<td>KRF</td>
<td>Kent Resilience Forum</td>
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<tr>
<td>LA</td>
<td>Local Authority</td>
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<td>LOEB</td>
<td>Local Outbreak Engagement board (Joint Health and Wellbeing Board)</td>
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<td>LOCP</td>
<td>Kent and Medway Local COVID-19 Outbreak Control Plan</td>
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<td>LRF</td>
<td>Local Resilience Forum</td>
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<td>LHRP</td>
<td>Local Health Resilience Partnership</td>
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<td>MAIC</td>
<td>Kent Resilience Forum – Multi Agency Information Cell</td>
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<td>MC</td>
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<td>Medicines and Healthcare Products Regulatory Agency</td>
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<td>National Health Service</td>
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<td>NPI</td>
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<td>PHC</td>
<td>Public Health Consultant</td>
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<td>PHE HPT</td>
<td>Public Health England South East - Kent and Medway Health Protection Team</td>
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<td>Kent Resilience Forum - Strategic Coordinating Group</td>
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<td>SITREP</td>
<td>Situation Report</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
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<td>SPOC</td>
<td>Single Point of Contact</td>
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<td>TCG</td>
<td>Tactical Coordinating Group</td>
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<td>UTLA</td>
<td>Upper Tier Local Authority</td>
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<td>ULA</td>
<td>Unitary Local Authority</td>
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<td>VCS</td>
<td>Voluntary and Community Sector</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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**Glossary**

**7-day rolling average**

This a measure of incidence or how many new cases of a disease have appeared in a given period of time. The 7-day rolling average takes the average number of cases reported per day in a shifting seven-day window. Reports could read as follows: ‘this is up 26% from an estimated 27,950 new cases per day for the period from October 2\(^{nd}\) to October 8\(^{th}\).’

**Acute NHS trusts**

Acute NHS trusts provide services such as accident and emergency departments, inpatient and outpatient medicine, surgery and in some cases very specialist medical care. They provide secondary care and refer to anything from small district hospitals to large city teaching hospitals.

**Antibodies**

Antibodies are proteins that help fight off infection and can provide protection against that disease occurring again (immunity). Antibodies are disease specific. Antibody tests are useful for determining if an individual has been recently exposed to COVID-19 but are not a reliable way for testing population immunity as they dissipate over time.

**Antigens**

Antigens are molecules that are capable of stimulating an immune response. An antigen test reveals if a person is currently infected with a pathogen such as SARS-CoV-2, the virus that causes COVID-19.

**Asymptomatic testing**

This refers to the testing of those who have no symptoms of COVID-19 to understand levels of asymptomatic transmission in a particular setting or the community at large. This is typically performed as part of a wider scientific study or to prevent inadvertent transmission within high-risk areas such as health and social care facilities.

**Clusters**

A cluster refers to the aggregation of cases in the same area at the same time. During the pandemic, the UK government has defined a cluster as two or more test Confirmed cases of COVID-19 among individuals associated with a specific non-residential setting with illness onset dates within a 14-day period. A cluster ends when there are no test Confirmed cases with illness onset dates in the previous 14 days.

**Communicable disease**

These are illnesses caused by viruses or bacteria that people spread to one another through contact with contaminated surfaces, bodily fluids, blood products, insect bites, or through the air.

**Community spread**

This term is used to describe the spread of a contagious disease within a certain community. During community spread there is no clear source of contact or infection.
Contact Tracing

This is the process of identifying those who have interacted with an infected individual and may be at risk of developing and passing on the disease themselves. Contact tracing helps alert others that they need to be tested for a particular disease and self-isolate if necessary.

Covid-19 alert levels

With levels set at medium, high, very high, and stay at home, this new four-tiered system matches the restrictiveness of infection control strategies to local case numbers. The ‘medium’ alert level (Level 1) – which currently covers most of the country – will only be subject to the national measures of the Rule of Six and the closure of hospitality at 10pm. The ‘high’ alert level (Level 2), meanwhile, will reflect many current local interventions but will apply much-needed consistency to response in these situations. Here, household to household transmission will be prevented by banning all mixing between households or support bubbles indoors and The Rule of Six is applied in outdoor spaces, including private gardens. The ‘very high’ alert level (Level 3) will be applied in areas where transmission, hospital admission and growth rates – especially amongst vulnerable groups - are causing great concern. People are not advised to travel in and out of Level 3 areas and local bars and pubs must close unless they are operating in a restaurant capacity (serving substantial meals). Finally, the ‘stay at home’ alert level (Level 4) will be applied in areas causing the greatest concern in regard to high transmission, hospital admission and growth rates especially amongst the vulnerable groups. People are not advised to travel in and out of Level 4 areas to other levels except for reasonable excuses such as work or education. People are advised not to meet other people indoors including over the Christmas and New Year period unless living with them or they are part of a support bubble. Outdoors, one can only meet one additional person from another household.

Director of Public Health (DPH)

Directors of Public Health are responsible for determining the overall vision and objectives for public health in a local area or in a defined area of public health, such as health protection. They are accountable for delivering public health objectives and reporting annually on the outcomes of interventions and future programmes of work.

Dynamic risk assessment

This is the practice of mentally observing, assessing and analysing an environment while work is underway to identify and remove risks in real-time.

Epidemiological modelling:

An epidemiological model is usually defined as ‘a mathematical and/or logical representation of the epidemiology of disease transmission and its associated processes’. These mathematical models can project how infectious diseases progress to show the likely outcome of an epidemic and help inform public health interventions. A variety of parameters are used to model the impact of a variety of interventions on the spread of an infectious disease within a given population; these models can help decide which interventions to avoid and which to trial.

Essential services

These are the occupations or services that are vital for the health and safety of the public during the pandemic. These should be open and active even in periods of lockdown.

Exposure
This term is used to describe coming into contact with someone positive for COVID-19. Risk of exposure can be reduced by following hand washing, maintaining social distance and wearing face-coverings. Bespoke information for health and social care workers on limiting exposure can be found here.

**Furlough**
A furlough is a temporary layoff, involuntary leave, or other modification of normal working hours for a specified duration. Over the course of the pandemic, the government has supported employers to furlough staff that they can no longer maintain due to the disruption COVID-19 has caused. The Coronavirus Job Retention Scheme provides employers with a grant to cover a portion of their furloughed employees’ monthly salaries. More information on this scheme can be found here.

**Hand hygiene**
This term refers to the regular practice of hand washing. The government recommends hand washing or at least 20 seconds using soap and water or hand sanitiser. Hands should be washed when arriving at work or returning home, after blowing the nose or coughing or sneezing and before eating or handling food.

**Health Protection Board (HPB)**
This entity monitors and responds to any rise in cases in a given area; they identify patterns of transmission and create local outbreak management plans for constituent councils.

**Home Testing**
Those who are symptomatic of COVID-19 can order home testing kits within the first 7 days of symptom onset. The test involves taking a swab of the inside of the nose and the back of the throat, using a long cotton bud. This swab can be performed by the patient (or their caregiver if aged under 11 or under). A home testing kit must be registered before it is sent back.

**Immunisation**
A process by which a person becomes protected against a disease through vaccination. This term is often used interchangeably with vaccination and more details can be found here.

**Incident Management Team (IMT)**
This term is used synonymously with Outbreak Control Team. More details can be found here.

**Information Governance**
This term refers to the legal framework that governs the use of personal confidential data in healthcare. This framework allows organisations and individuals to ensure that personal information is handled legally, securely, efficiently and effectively in order to support delivery of the best possible care.

**Joint Biosecurity Centre (JBC)**
The Joint Biosecurity Centre (JBC) provides evidence-based, objective analysis to inform local and national decision-making in response to COVID-19 outbreaks. This includes helping to inform action on testing, contact tracing and local outbreak management in England, informing an assessment of the risks to UK public health from inbound international travel and advising on the COVID-19 alert level. More information can be found here.
Key workers
Key, critical or essential workers are those who have jobs that are vital to public health and safety during the pandemic. Because their work is so vital, the government is attempting to enable them to carry out their jobs with as little restriction as possible. Key workers are provided with streamlined testing services and are able to put their children in school and use necessary transport links even during national lockdown. The list of key workers can be found here.

Mobile testing units
These units visit different locations and can be set up to test clients in as little as 20 minutes. These units are generally operated by the Armed Forces and respond to areas of highest demand to augment existing testing services and increase daily testing capacity in that area.

Mutual Aid
Mutual aid groups are self-organised groups of volunteers dedicated to supporting and helping people in need in their communities. There is no uniform way to develop a group and each group is advised to work in a way which best benefits their community. Tasks may include leafleting, providing emotional support or contact for the isolated or running errands and shopping for those who cannot do so themselves.

NHS Test and Trace
NHS Test and Trace (NHSTT) is England's COVID-19 contact tracing programme. It was launched on 28 May and is a central part of the UK’s COVID-19 response strategy. This work is dedicated to testing for COVID-19 in the community and tracing contacts of all those who prove to be positive for the virus. The new NHS COVID-19 app is the Official NHS contact tracing app for England and Wales. It is the fastest way of knowing when you’re at risk from Coronavirus.

Non-essential services
These are occupations or services that are not absolutely necessary for the health of the public during the pandemic. These would be closed or forced to pivot to ‘working from home’ arrangements in periods of lockdown or when rates of disease transmission are high in a community.

Non-pharmaceutical interventions (NPI)
These are public health measures that aim to prevent and/or control disease transmission in the community. NPIs are one of the most effective public health interventions against COVID-19. Specific recommendations to protect the most vulnerable include enhanced surveillance, comprehensive testing, and intensified infection prevention and control practices in settings that host high-risk individuals, such as long-term care facilities. When community transmission is a factor, NPIs include the use of face coverings, social distancing, hand hygiene and respiratory etiquette.

Outbreak Control Team (OCT)
The decision to convene an Outbreak Control Team is made on a case-by-case basis, generally by the Director responsible for infection prevention and control in a given unit, facility or area. The Outbreak Control Team is responsible for the following: reviewing outbreak evidence, recommending control measures based on risk assessment, agreeing further investigations, establishing OCT membership, assigning individual responsibilities to OCT members, determining what resources are needed in a given
area, entering surveillance data to monitor progress, communicating with the public/media, deciding criteria for declaring the outbreak over and producing and circulating a final report. An Outbreak Control Team is composed of representatives from a variety of fields of medicine including Virology, Toxicology, Epidemiology, Microbiology as well as regulators (e.g. representatives from health and safety, food standards agency, environmental agencies etc) and communication and legal experts. More details can be found here.

**Outbreaks**

During the pandemic, the UK government has defined an outbreak as two or more test-confirmed cases of COVID-19 among individuals associated with a specific non-residential setting with illness onset dates within 14 days and one of the following two criteria: 1) identified direct exposure between at least 2 of the test-confirmed cases in that setting during the infectious period of one of the cases or 2) when there is no sustained local community transmission. The threshold for the end of an outbreak is higher than the end of a cluster: here there must be no test-confirmed cases with illness onset dates in the previous 28 days in that setting. More information on this can be found here.

**Personal Protective Equipment (PPE)**

PPE refers to the items of clothing worn by medical and social care professionals to limit their exposure to a disease or hazard. HEE has created a comprehensive guide to PPE which can be accessed here. To help prevent transmission of COVID-19, guides have also been made to direct PPE usage in a range of both clinical and non-clinical settings. These can be accessed here.

**Pillar 1 testing**

This refers to all swab testing carried out in Public Health England laboratories and NHS hospitals for those with a clinical need and for health and care workers.

**Pillar 2 testing**

This refers to all swab testing that is conducted amongst the wider population, as set out within government guidance.

**Pillar 3 testing**

This refers to serology testing to show if people have antibodies from having had COVID-19 in the past.

**Pillar 4 testing**

This refers to all blood and swab testing that is conducted for national surveillance purposes to learn more about the prevalence and spread of the virus and for other testing research purposes.

**Polymerase Chain Reaction Testing (not-rapid)**

The PCR test looks for evidence that the virus is currently in your body, by detecting the presence of its RNA in a swab sample from the nose/throat. The PCR test detects the genetic material in the virus called RNA. When the sample reaches the lab, a solution known as a ‘reagent’ is added to it. If there is virus present this reagent starts a ‘chain reaction’ and creates billions of copies of the genetic material in the virus so that there is enough that it can be detected and analysed by scientists to provide a positive result. The test usually takes between 12 and 24 hours to return a result.
Positivity rates
The positivity rate is the percentage of people who test positive for the virus out of those who have been tested overall.

Prevalence
This is a measure of the proportion of cases in the population at a given time.

Primary Care
This refers to healthcare services that are provided in the community and represent an initial approach to a medical practitioner or clinic for advice or treatment.

Public Health England Protection Team (PHE HPT)
Local health protection teams provide specialist support to prevent and reduce the effect of infectious diseases, chemical and radiation hazards, and major emergencies. Their activities include; local disease surveillance, maintaining alert systems, investigating and managing health protection incidents and outbreaks and delivering and monitoring national action plans for infectious diseases at local level.

Quarantine
The time in which an infected individual should self-isolate in their own homes. If living with others, this person should eliminate all interaction with co-inhabitants; this includes living in a separate room and using separate cutlery, plates, cooking instruments and towels, for example, as well as bathroom facilities.

Rapid Testing – multiple types Antigen Testing, LAMP testing, Lateral Flow Technologies
Most current diagnostic tests that detect SARS-CoV-2 genetic material are PCR-based, due to its high levels of sensitivity and specificity. However, this method can be expensive, slow, and requires sophisticated equipment and well-trained personnel; it is not suitable for point-of-care use. Rapid tests are designed to tell in a few minutes whether a person is positive or negative for a given pathogen. Rapid testing is appealing because receiving fast results means a person knows sooner whether they need to isolate to avoid transmitting the virus to others. A variety of rapid testing types are available for COVID-19 including Covid Nudge, Sofia, Veritor, BinaxNow and LumiraDx (which are all rapid antigen tests) and ID NOW, conas, Cue COVID-19Test, Xpert Xpress and Accula (which are all real time polymerase chain reaction tests). Loop-mediated Isothermal Amplification (LAMP) is another method being leveraged for rapid COVID testing; like PCR, this also amplifies DNA/RNA. Lateral Flow Tests have also been piloted for use in mass surveillance studies; these utilise paper-based assays for the rapid detection and quantification of COVID-19 antigens.

Regional Test Sites
These test sites are permanent testing hubs in a given region. They are either walk-in or drive-in.

Risk-factor
These are the variables which would make an individual more likely to develop or contract a disease than those who were not affected by said variable.
Satellite testing units
These testing units are processed by private labs and are set up in places like care homes or hospitals. Like mobile testing units, satellite testing units also increase a region’s testing capabilities and are primarily dedicated to testing health and social workers.

Secondary Care
This refers to healthcare services that are provided by health professionals who generally don’t have first contact with a patient. Secondary care services are usually based in a hospital or clinic though some may still reside in the community.

Self-isolation
This term refers to the period of time that those who have become symptomatic of COVID-19 or have recently been exposed to COVID-19 should remove themselves from work, school and all forms of in-person socialising to stay within the home. Current government guidance on self-isolation can be found here.

Shielding
This term refers to the self-isolation imposed by those from clinically extremely vulnerable groups who are attempting to reduce their likelihood of contracting COVID-19. Those identified as being eligible for shielding will have received a letter from the NHS or their GP to inform them of their high risk and provide them with guidance on how to shield effectively. In the first wave of the pandemic this advice was particularly stringent and isolating – the advice available today (available here) is significantly less restrictive.

Social distancing
Social distancing, also called “physical distancing,” means keeping a safe space between yourself and other people who are not from your household. To practice social or physical distancing, stay at least 2 meters from other people who are not from your household in both indoor and outdoor spaces. If this is not possible then face coverings should be worn, particularly in indoor spaces.

Statutory Sick Pay
If a person is too sick to work, they are awarded a minimum of £95.85 per week for up to 28 weeks. SSP is awarded to those who are self-isolating or living in an area with local restrictions in place.

The Reproduction (R) Value
The reproduction value is a way of rating coronavirus or any disease's ability to spread. It's the number of people that one infected person will pass on a virus to, on average. For example, an R Value of 6.7 would mean each sick person was expected to pass the illness on to between 6 and 7 other people.

VCS organisations
This term refers to all organisations that make up the volunteering and community sector. These can include community groups, social enterprises and co-operatives.
**Vaccination**

The act of introducing a vaccine into the body to produce immunity to a specific disease. A simple, safe, and effective way of protecting people against harmful diseases before they come into contact with them. This term refers to the administering of safe agent-specific antigenic components that in vaccinated individuals can induce a protective immunity against the corresponding infectious agent. More information can be found [here](#).

**Vaccine**

This term refers to a product that stimulates a person’s immune system to produce immunity to a specific disease, protecting the person from that disease. Vaccines train the immune system to create antibodies, just as it does when it’s exposed to a disease. However, because vaccines contain only killed or weakened forms of germs like viruses or bacteria, they do not cause the disease or put one at risk of its complications. More information can be found [here](#).
Executive Summary

As part of the UK government’s COVID-19 recovery strategy, the NHS Test and Trace service was launched on 28th May 2020 with the primary objective to control the COVID-19 reproduction (R) rate; by reducing the spread of infection, it is possible to save lives, protect the nation’s health and care services and get the UK back to a place of ‘normality’ and economic prosperity. Achieving these objectives requires a coordinated effort between local government, the National Health Service, Public Health England, the police and other relevant organisations at the centre of outbreak response. These ways of working are set out in a Local Outbreak Control Plan.

In Kent and Medway, the Kent Resilience Forum COVID-19 Local Outbreak Control Plan builds on existing health protection plans already in place between Kent County Council, Medway Council, Public Health England - South East, the 12 Kent District and Borough Council Environmental Health Teams, the Strategic Coordinating Group of the Kent Resilience Forum, Kent and Medway Clinical Commissioning Group and other key partners. Summarised in 8 themes, the Kent Resilience Forum COVID-19 Local Outbreak Control Plan sets out how local actors aim to protect Kent and Medway’s population by:

- Preventing the spread of COVID-19
- Identifying early and proactively managing local outbreaks
- Coordinating capabilities across agencies and stakeholders and;
- Communicating with and assuring the public and partners that the plan is being effectively delivered

Said 8 themes are summarised below:

1. Governance structures that have been established and are led by the Kent and Medway COVID-19 Health Protection Board and supported by the Strategic Coordinating Group of the Kent Resilience Forum, Kent County Council & Medway Council through the Kent and Medway Joint Health and Wellbeing Board. In addition, both Kent County Council and Medway Council have specific oversight arrangements to take account of their public duties and responsibilities (Section 4)

2. Arrangements to manage care homes & education setting outbreaks including defining monitoring arrangements, identifying potential scenarios and planning required responses (Section 5)

3. Arrangements in place to manage outbreaks in other high-risk places, locations and communities of interest including sheltered housing, transport access points & detained settings including defining monitoring arrangements, identifying potential scenarios, and planning required responses (Section 5)

4. Managing the deployment and prioritisation of services available for local testing which allows for a population level swift response. This includes delivering tests to isolated individuals, establishing local pop-up sites and hosting mobile testing units at high-risk locations (Section 6)
5. Monitoring local and regional contact tracing and infection control capability in complex settings and the need for mutual aid, including developing options to scale capacity if needed (Section 7)
6. Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook (Section 8)
7. Supporting vulnerable local people to get help to self-isolate and ensuring services meet the needs of diverse communities (Section 9)
8. Communicating with the public and local partners in Kent and Medway; essential for managing outbreaks effectively (Section 10)

For the sake of transparency, accountability and freedom of information, The Kent Resilience Forum COVID-19 Local Outbreak Control Plan - including its Appendices of setting specific action cards - should be read by the public alongside local decision makers, businesses, advisors and stakeholders most likely to be affected by COVID-19.

We are grateful to our teams and many colleagues from the Councils, Kent and Medway Clinical Commissioning Group, the Kent Resilience Forum, Public Health England and other organisations for their unwavering support and contributions in protecting Kent and Medway’s population from harm during the COVID-19 pandemic.

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1. Introduction

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of an unknown cause detected in Wuhan City, Hubei Province, China [1]. On 12 January 2020 it was announced that a novel coronavirus had been identified; this virus was classified as SARS-CoV-2 and its resultant disease became known Coronavirus Disease 2019 - COVID-19 for short [2]. On 11th March 2020 the WHO declared the COVID-19 outbreak a pandemic [3]. As of the 14th of December, 76,046,387 cases of COVID-19 have been reported including 1,693,858 deaths [4]. Updated figures for the UK - alongside local breakdowns - can be obtained via this government dashboard.

On the 2nd of December 2020, MHRA approved the Pfizer vaccine. The COVID-19 vaccine has now been implemented and it comes in doses of 975, must be stored at -70 degrees and must be used within 5 days once thawed. Soon after the development of the COVID vaccine, a novel variant of COVID-19 (SARS-COV-2) was identified which has spread rapidly within the UK. Backward tracing using genetic evidence suggests that the new variant emerged in September 2020. Data from Whole Genome Sequencing, epidemiology and modelling suggest the new variant transmits more easily than other variants.

The UK Government’s response strategy for managing the COVID-19 pandemic has now entered its next phase. Up to date information about the national response can be found here [5]. After a brief interlude of controlled re-opening this summer, tighter restrictions have had to return to prevent a second wave of cases from overwhelming NHS capacity. Additional support is required to ensure that the NHS Test and Trace service [6] achieves its full potential over the coming winter months.

Under the Health and Social Care Act 2012 [7], Directors of Public Health (DPH) in upper tier (UTLA) and unitary (ULA) local authorities have a specific duty to protect the population’s health. They must ensure plans are in place to respond to and manage threats such as communicable disease outbreaks which present a public health risk. DPHs fulfil this duty through collaboration across a range of partners. These include local authority (LA) environmental and public health teams (including consultants in public health), Public Health England (PHE), National Health Service (NHS) organisations and other agencies.

As part of the UK Government’s COVID-19 recovery strategy, the DHSC has mandated the development of local COVID-19 Local Outbreak Control Plans by UTLA and ULAs. National government has provided LAs with £300 million in additional funding to support delivery of these LOCPs.
1.1. Purpose & Scope

The Kent Resilience Forum COVID-19 Local Outbreak Control Plan (LOCP) will augment existing health protection arrangements in place within Kent and Medway. This plan will enable additional specific action to be taken to address COVID-19 outbreaks. Its aims and themes are set out in the Executive Summary.

The LOCP is based on Public Health Outbreak Management Standards [8], and health protection functions for local government. These functions are outlined in "Health Protection in Local Government Guidance" [9] placing primary health protection roles at both District/Borough and County Council level, with other functions sitting with PHE and the Guiding Principles for Effective Management of COVID-19 at a Local Level [10].

The LOCP includes;
- Kent County Council (KCC) and Medway Council’s (MC) resilience and recovery strategies including their work with key settings, communities, and populations to prevent, identify and control outbreaks, facilitate communication, and meet any additional needs.
- Specific roles, responsibilities, and individual arrangements across Kent Resilience Forum (KRF) partner organisations in relation to the prevention, identification, and reaction to COVID-19 outbreaks.
- KRF-wide information and communication flow maps including key processes to be followed proactively day-to-day (e.g. infection control) and in the case of COVID-19 outbreaks.
- Trigger points for escalation and deployment of certain processes
- Existing national, regional, and local level plans (e.g. Action Cards & Standard Operating Procedures) for high risk locations & vulnerable populations
- Proactive and reactive communications and engagement plans including prepared / example materials and data usage to tailor messaging.

Please see Section 7.2 for instructions on how to activate this plan.

1.2. Linked plans

The LOCP builds on the following plans:
1. Kent and Medway, Surrey & Sussex PHE Centre Outbreak/Incident Control Plan
2. KCC – Major Emergency Plan
3. MC – Major Response Strategy
4. KCC – Emergency Recovery Plan
5. MC – Emergency Recovery Plan
6. KRF Pan Kent Strategic Emergency Response Framework
7. KRF COVID-19 Evacuation and Shelter Plan
8. KRF Media and Communications Plan
9. KRF Vulnerable People & Communities Framework
10. KRF Identifying & Supporting Vulnerable People Plan
11. KRF Pan Kent Strategic Recovery Framework
2. Kent and Medway in Context

An estimated 1.8 million people live in Kent and Medway [11]. KCC is an UTLA and comprises 12 borough & district councils inhabited by circa 1.5 million people [12]. MC is a ULA with circa 280,000 residents [13]. Together, they make up one of the most densely populated areas in England.

2.1 Health Needs of Residents

- Life expectancy at birth is similar to England’s national average [14] in Kent and lower than national average in Medway for men (79.9 in Kent, 79.0 in Medway) and women (83.4 in Kent, 82.6 in Medway) [15].
- Adult smoking (15% in Kent, 14.7% in Medway) and overweight or obesity prevalence (64.2% in Kent, 69.6% in Medway) are similar to England’s national average [15]. Obesity is known to be a COVID-19 risk-factor [16].
- Increasing age is known to be a COVID-19 risk factor [16] and 19.4% of Kent’s [17] and 15.9% of Medway’s residents [13] are aged 65+.
- Non-white ethnicity is also known to be a COVID-19 risk-factor [16]. In Kent, 6.6% of the population are of Black Asian and Minority Ethnic (BAME) origin with the largest single BAME group represented by Asian Indians at 1.2% of the total population [18]. In Medway, 10.4% of the total population identified as BAME with Asian Indians the largest proportion at 2.7% [19].
- A 2016 report found there to be significant inequalities in the health outcomes, health behaviours, risk factors and wider health determinants among Kent and Medway’s residents, with premature mortality from respiratory disease 3 times higher amongst the most deprived compared with the least deprived [20].
- The mortality gap between least and most deprived is widening suggesting increasing health inequalities [14].

2.2 Health & Social Care Landscape

The *Kent and Medway Sustainability and Transformation Plan* is aiming to establish an Integrated Care System by April 2021 [22]. Organisations involved in the delivery and/or support of Kent and Medway residents’ health and social care needs include:
- 220 + General Practice (GP) Surgeries
- 24 Hospitals
- 342 Pharmacies
- 429 Dentists
- 42 Primary Care Networks
- 4 Integrated Care Partnerships (Dartford, Gravesham & Swanley; East Kent; Medway & Swale; and West Kent)
- 4 Acute Trusts (including 3 Foundation Trusts)
- 1 UTLA (KCC)
- 1 ULA (MC)
- 1 Mental Health Trust
- 2 Community Health Trusts
2.3 The Impact of COVID-19

Cases
According to reporting by Kent and Medway’s Health Protection Board as of December 15th, 2020, there have been a total of 52,912 lab-confirmed cases of COVID-19 in Kent and Medway reported to PHE [21]. After a significant lull within the summer months, the current rate of infection has risen to 2865.6 cases per 100,000 population [21], amongst the very worst in the entire UK.

As of December 20th 2020, London, South East and East of England regions have confirmed the largest number of cases with the novel variant in England. However, there is no evidence currently that the variant is more likely to cause severe disease or mortality. There are continued worries about compliance with social distancing and infection control across both care and commercial settings at this time [22]. Moreover, there is significant concern around forecasted clinical demand in the coming weeks due to pressure on the Kent and Medway hospitals and bed shortages. Cases are now increasing across multiple age demographics; these increases are most notable within children of primary school age, adults between the ages of 25 and 44 and – most recently – in those above the age of 85 years [22].

Covid-19 Vaccine
Covid-19 vaccination started on the 12th of December 2020 at William Harvey Hospital and the first vaccination centre to go live is the Aylesham Health Centre. The current focus of CoVID-19 vaccination is on those who are over the age of 80 and care home staff.

Delivery of the vaccine is through 4 delivery models;
- Hospital Hubs- places where the vaccine is received and administered (William Harvey, MFT etc)
- Vaccination centre- larger sites to vaccinate staff not on hospital sites and general populations
- PCN centres- to vaccinate NHS community staff
- Roving Model- for those who are in care homes or housebound
3. Legal Context

The DPHs in UTLA and ULAs have a statutory duty to prepare for and lead the LA public health response to incidents that present a threat to the public’s health. As such, they are responsible for developing the LOCP and will work closely with local partners to control and manage the spread of COVID-19 outbreaks as part of a single public health system. Specific legislation to assist in outbreak control of COVID-19 in the UK is detailed below.

3.1. Coronavirus Act 2020

Under the Coronavirus Act [23], the Health Protection (Coronavirus Restriction) (England) Regulations 2020 as amended [24] sets out the current restrictions and regulations in place as well as the powers that DPHs from UTLAs and ULAs can draw on in order to respond to an outbreak and control the transmission of COVID-19 in its area. They will have the authority to close individual premises and public outdoor places as well as restrict events with immediate effect if they conclude it is necessary and proportionate to do so without making representations to a magistrate. The use of these powers should be an option of last resort where individuals or organisations are unable, unwilling, or opposed to taking actions that reduce the spread of this virus. The powers of the police to enforce restrictions, closures and lockdown measures also flow from these regulations.

Premises which form part of essential infrastructure will not be in scope of these powers and DPHs will therefore need to engage with the setting owner and the NHS Test and Trace Regional Support and Assurance team, who will work with the relevant government department to determine the best course of action.

In exercising any of these powers the UTLA/ULA must notify the Secretary of State as soon as reasonably practicable after the direction is given and review to ensure that the basis for the direction continues to be met, at least once every 7 days. UTLA/ULAs may also seek support from ministers to use powers under the Coronavirus Act 2020 [23] to close schools or limit schools to set year groups attendance, to cancel or place restrictions on organised events or gatherings, or to close premises.

3.2. Health Protection Regulations 2010 (as amended)

The powers contained in the suite of Health Protection Regulations 2020 as amended [24], sit with district and borough council and ULA Environmental Health teams.

The Health Protection (Local Authority Powers) Regulations 2010 [25] allows a LA to serve notice on any person with a request to cooperate for health protection purposes to prevent, protect against, control or provide a public health response to the spread of infection which could present significant harm to human health.

The Health Protection (Part 2A Orders) Regulations 2010 [26] allow a LA to apply to a magistrates’ court for an order requiring a person to undertake specified health measures for a maximum
period of 28 days. These Orders are a last resort, requiring specific criteria to be met and are labour intensive. These Orders were not designed for the purpose of ‘localised’ lockdowns, so it is possible that there may be a reluctance by the Courts to impose such restrictions and the potential for legal challenge.

3.3. Data Sharing

There will be a proactive approach to sharing information between local responders, in line with the instructions from the Secretary of State, the statement of the Information Commissioner on COVID-19 and the Civil Contingencies Act 2004 [27]. Further details regarding data sharing and information governance can be found in Section 8.4
4. Theme 1 - Governance Structure

The *Guiding Principles for Effective Management of COVID-19 at a Local Level* sets out that ULA and UTLA Chief Executives, in partnership with the Director of Public Health and Public Health England Health Protection Team, are responsible for signing off the Local Outbreak Control Plan [10].

Alongside the development of LOCPs, it recommends the formation of three critical local roles in outbreak planning alongside community leadership. Additional cells and groups will also directly feed into the LOCP which includes the KRF COVID-19 Care Home Cell, the KRF COVID-19 Health & Social Care Cell & the KRF COVID-19 Contact Tracing Workstream. A summary of the Kent and Medway governance structure is outlined in Figure 1.

4.1. Kent and Medway Health Protection Board

In line with above, the Kent and Medway COVID-19 Health Protection Board (HPB) was formed and convened on 1st June 2020. Led by the Public Health Departments of KCC and MC, the HPB links together established governance structures across KCC, MC, Public Health England South East - Kent and Medway Health Protection Team (PHE HPT), the 12 district and borough council Environmental Health teams, Kent Resilience Forum - Strategic Coordinating Group, Kent and Medway CCG and other key partners.

It meets weekly depending on operational requirements and serves to ensure effective system wide collaboration whilst providing strategic oversight for both the development and delivery of the KRF COVID-19 Local Outbreak Control Plan.

4.2. Kent Resilience Forum – Strategic Coordinating Group

The Kent Resilience Forum is the Local Resilience Forum for Kent and Medway and within this sits the Strategic Coordinating Group (KRF SCG). The HPB will work with the KRF SCG who will deliver the LOCP by working through pre-existing structures that are in place with local stakeholders and organisations. The KRF SCG will support local health protection arrangements working through the Tactical Co-ordinating Group (TCG) and the following cells:

- KRF COVID-19 Testing Cell
- KRF COVID-19 Health and Social Care Cell (HSCC)
- KRF COVID-19 Multi Agency Information Cell (MAIC)
- KRF COVID-19 Vulnerable People and Communities Cell
- KRF COVID-19 Contact Tracing Workstream

4.3. Kent and Medway Local Outbreak Engagement Board

As stipulated by the DHSC, there is a need for a Local Outbreak Engagement Board (LOEB) to provide political ownership & facilitate public and stakeholder engagement for the COVID-19 Local Outbreak Control Plan. In Kent and Medway, the LOEB will be the Kent and Medway Joint Health and Wellbeing Board. Operationally there are additional layers of engagement and governance,
that sit within the structures of KCC and MC. These structures serve to enable the LAs to discharge their specific public health responsibilities. They also serve to ensure oversight of other elements of LA specific responsibilities. For example, there will be regular member engagement through the Kent Leaders Forum comprising elected council leaders from all LAs across Kent and Medway.

5. Themes 2 & 3 - Identification of Complex Settings

This section delineates the settings, places and communities that are considered high-risk or complex. This could be because there is a risk of significant onward transmission, or there are clinically vulnerable individuals based at that setting (e.g. care homes and schools).

These settings have been identified as complex settings by PHE HPT. This means there are specific arrangements for the prevention, identification and management of cases, community clusters or outbreaks in these settings (see Section 7)

The list of identified complex settings in Kent and Medway can be found in Table 1. Each setting has a specific action card embedded within the Appendix which is signposted from Table 1. These cards;

1. outline the triggers, process and required response for each setting, the resource capabilities and capacity implications and what current plans are in place to support these settings.
2. have been designed to be used by those who have responsibility for an individual setting, providing a single point of access to key information on how to minimize outbreak risks and guidance on what to do if someone reports symptoms of or tests positive for COVID-19.

3. provide a transparent and consistent approach when working with PHE HPT, KCC/MC and other local partners and are intended to complement existing systems and processes for managing infectious diseases.

4. include the PHE and NHS T&T outbreak management action cards for particular settings which can also be found online [here](#).

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**Table 1 – List of Complex Settings and the Location of their COVID-19 Action Cards**

<table>
<thead>
<tr>
<th>Complex Setting</th>
<th>Location of Action Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Homes</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>Schools &amp; Other Educational Settings</td>
<td>Appendix 2</td>
</tr>
<tr>
<td>Other Health and Social Care Settings</td>
<td>Appendix 3</td>
</tr>
<tr>
<td>Shelter Refuges and Hostels</td>
<td>Appendix 4</td>
</tr>
<tr>
<td>Prisons &amp; Detention Facilities</td>
<td>Appendix 5</td>
</tr>
<tr>
<td>Other Workplace Settings</td>
<td>Appendix 6</td>
</tr>
<tr>
<td>Transport arriving at Ports and Borders</td>
<td>Appendix 7</td>
</tr>
<tr>
<td>Other Transport</td>
<td>Appendix 8</td>
</tr>
<tr>
<td>Outdoor Settings</td>
<td>Appendix 9</td>
</tr>
</tbody>
</table>
6. Theme 4 - Testing

Testing & Contact Tracing (see Section 7) are a fundamental part of COVID-19 outbreak control. By monitoring COVID-19 closely, it should be possible to isolate infectious persons, prevent & mitigate outbreaks, and detect early warning signs of COVID-19’s spread both locally and nationally. This section outlines the key steps of the local testing arrangements in place in Kent and Medway.

The national testing response is grouped around four pillars – information on each is provided below:

- Pillar 1: PCR swab testing in PHE labs and NHS hospitals for those with a clinical need, for health and care workers, and to help manage outbreaks - including in care homes. Tests are conducted in hospitals and outbreak locations. P1 capacity is made up of NHS and PHE labs across the devolved administrations. Each devolved administration is responsible for the utilisation of their testing capacity.
- Pillar 2: PCR swab testing for the wider population administered by commercial partners across the UK. Tests are provided through regional testing sites, mobile testing units, surveillance sites and home testing kits and are processed at Lighthouse labs.
- Pillar 3: Antibody testing administered by PHE. These are serology tests to show if people have antibodies from having had COVID-19.
- Pillar 4: PCR swab testing for large-scale surveillance studies on the spread of COVID-19. Tests are administered by PHE and commercial partners.

For the purposes of the LOCP, we shall only discuss PCR antigen testing as this is the primary method used for testing, contact tracing and outbreak management in Kent and Medway. However, new rapid testing technologies are being piloted across the UK and are beginning to be operationalised in clinical settings e.g., LamPORE rapid tests and options that utilise lateral flow technology. LFDs for instance are currently added to staff’s weekly PCR testing in care homes with outbreaks in response to the new COVID-19 variant (nv-SARS-Co-V2) issues.

6.1. Access to Tests

Depending on the situation and setting, there are different routes by which a person can access testing. The NHS Test & Trace (NHS T&T) system is the main route of public access to tests for COVID-19 [28]. These include home test kits, drive through regional test sites, satellite test sites, mobile testing units and dedicated local testing centres. In addition to these, there are testing systems set up by NHS hospitals and other commercial testing facilities.

The NHS T&T locations for Kent and Medway are demand responsive and therefore change on a continual basis. A combination of regional, local, satellite and mobile test sites provide coverage for Kent and Medway residents either by foot or by car. Details of current locations of the Kent and Medway NHS T&T sites are available from hscc@medway.gov.uk. A national Winterification plan for local test sites will be actioned in the coming months to ensure that adverse weather conditions do not impact testing uptake and turnaround times.
In the vast majority of cases, a person will only be eligible for testing if they are showing symptoms of COVID-19. However, in light of new evidence showing that people infected with COVID-19 who are either pre-symptomatic or have very mild or no respiratory symptoms (asymptomatic) can transmit the virus to others without knowing, there are instances where certain people/groups in Kent and Medway will be eligible for asymptomatic testing. This includes:

- Emergency admissions
- Elective patients tested prior to admission and, if negative, then re-tested upon onset of symptoms or after 5-7 days
- Elective patients tested prior to admission to the independent sector, by local agreement, for NHS patients and, if negative, then re-tested upon onset of symptoms or after 5-7 days
- Upon discharge to other care settings including care homes/hospices
- Untoward Incidents - Any untoward incident in terms of probable healthcare associated COVID-19.
- Outbreaks and Clusters - An outbreak, classed as two or more cases in a single setting. For example, if two patients in a ward test positive the whole ward (patients and staff) should be tested.
- If a healthcare worker tests positive the colleagues who they’ve been in contact with should be identified and tested (as part of Track and Trace).
- Periodic health and social care staff testing as part of PHE’s SIREN study.
- Periodic testing of all eligible care home staff (including agency staff and volunteers) every 7 days and residents every 28 days. Eligible care homes are those with residents aged 65+ and/or with dementia.
- Prison staff

Spare capacity for asymptomatic staff testing is not to be used outside of the above guidance. Further details on ensuring adequate testing access for Kent and Medway’s workforce can be found in Section 6.3.

6.2. Testing Results and Outcomes

National guidance for the public concerning test results can be found here [29]. In the event of a negative result, no further action is needed from the NHS T&T service. However, those who have been notified to have, or have been in contact with a person who has, COVID-19 should isolate [30]. In the event of a positive test result, contact tracing services will be initiated. The PHE HPT is notified when individuals from high-risk settings require follow up. NHS Trusts inform PHE about outbreaks, but not single cases. All results processed through accredited labs are added to the SGSS which feeds into NHS test and trace.

6.3. Assuring Local Testing Capacity

An assessment of the current use of mobile, satellite and drive through testing units, levels of need and COVID-19 infection rates in Kent and Medway, will enable risk and interventions to be
aligned to support outbreak management. Testing data will be reviewed by the KRF COVID-19 Testing Cell who have oversight of arrangements for testing of:

- Essential workers (including staff from Kent and Medway’s local public sector agencies, national public agencies based in or assigned to Kent and Medway, suppliers of essential services/contractors, agency workers, interims or consultancies directly engaged by Kent and Medway’s public agencies, and other organisations or businesses who are directly assigned to support the response). A list of essential workers can be found here [31]
- Wider resident testing as per government guidance (including care home residents and those in group living settings such as extra care, supported living and prisons in Kent and Medway)
- If there is the need to move to asymptomatic testing of essential workers there is additional point of care testing laboratory capacity.

The KRF COVID-19 Testing Cell reports to the HSCC & the HPB. See Section 4 for further details of Kent and Medway’s governance arrangements.

KCC and MC will be required to support Pillar 1 of the national testing strategy [32]; to scale up NHS swab testing for those with a medical need and, where possible, the most critical key workers and also for outbreak management. If enhanced support and testing capacity is required, DPHs can escalate to the national government command structure.

In the instance of increased demand on the testing system leading to a reduction in availability of booking for Pillar 2 testing, the COVID-19 Testing Workstream will work with acute trusts to ensure key workers are still able to access testing under Pillar 1, that Pillar 1 testing can be used to respond to outbreak and that PCR testing is prioritised over antibody tests.

Medway and Kent County Council has launched a mass COVID-19 rapid testing pilot for asymptomatic residents. Medway Council has successfully launched four permanent sites and multiple pop-up sites for this purpose; Kent County Council is in the process of launching its first sites.

Underpinned by Lateral Flow Tests (LFTs), this rapid testing pilot will enable Medway and Kent County Council to better understand levels of asymptomatic transmission in their communities. LFTs process human nasal swabs, throat swabs, or sputum samples with a Lateral Flow Device (LFD). If SARS-CoV-2 antigens are present in the person’s sample, a coloured line appears on the device after 10-20 minutes, signalling a positive result; its absence – after 30 minutes of waiting - indicates a negative result.

LFTs have previously been used to great effect in mass testing pilot studies. In Liverpool, over 122,000 residents have tested for COVID-19 using LFTs; just over 1,200 LFTs have returned positive tests. Liverpool’s success reducing their rate from 635 per 100,000 in mid-October to 106 per 100,000 (moving them from Tier 3 to Tier 2) was largely attributed to these mass testing efforts.

This pilot is operating in accordance with a framework provided by the Department of Health and
Social Care. Those eligible for testing are contacted via text, NHSNoreply or letter. The pilot will prioritise key and essential workers across Medway and Kent County Councils in the first instance, including all those that work within blue light services, social care, education, the military and within critical infrastructure. The dependents of these employees will also be eligible for testing, however, only those over 18 will be able to self-swab – those under the age of 18 must be accompanied by a consent parent/guardian. Residents living in local COVID-19 hotspots will also soon be invited to take part in this pilot. All those taking part must be asymptomatic for symptoms of COVID-19, however.

All tests are booked in advance via an online self-registration form. Once completed, individuals will be allocated a test slot and/or test group. Once at the test site, test subjects will have to register their attendance via the digital platform RegLite (this will be accessible through a QR code or weblink). Finally, test operatives at the testing site will be able to log results using the mobile app “Log Results”. If the result of LFD is positive, the person in question will be asked to perform a confirmatory PCR swab and self-isolate for 10 days (in line with normal NHS Test and Trace procedures). The details of positive cases and their most recent movements and contacts will then be entered into local and national Test and Trace records to alert said close contacts to seek testing if symptomatic and to break additional chains of infection.

It is hoped that the success of this pilot will lessen the burden placed on PCR testing capabilities and will help to curb the accelerating rates of transmission seen locally. That said, it is still to be determined as to whether LFTs will be used to facilitate entry in sensitive settings or key border sites.
7. Theme 5 - Contact Tracing & Outbreak Management

7.1. Contact Tracing

The Trace component of NHS T&T is an integrated service to identify, alert and support those who need to self-isolate. It is run by the Contact Tracing and Advisory Service (CTAS) which is jointly led by NHS England and PHE and is made up of three tiers of contact tracers. The roles of each CTAS tier is outlined in Figure 3.

All positive cases are initially referred to Tier 2 CTAS from a range of NHS T&T testing sources who will then obtain further information on details of places they have visited, and people they have been in contact with. These contacts are risk-assessed according to the type and duration of that contact. Those who are classed as ‘close contacts’ are contacted and provided with advice on what they should do e.g. self-isolate. Depending on the case or setting complexity, contact tracing and other health protection functions may be escalated to be handled by one of the higher CTAS tiers.

![Figure 2 – Contact Tracing Advisory Service (CTAS) Contact Tracing Tiers](image)

- **Tier 3** – Around 20,000 call handlers have been recruited by external providers under contract to DHSC to provide advice to contacts using national standard operating procedures (SOPs) and scripts as appropriate.

- **Tier 2** – Around 3,000 dedicated professional contact tracing staff have been recruited by NHS providers to interview cases to determine who they have been in close contact with in the two days before they became ill and since they have had symptoms. They will also handle issues escalated from Tier 3. Appropriate advice following national guidance is given to cases and their close contacts.
● **Tier 1** – PHE HPT will investigate cases escalated from Tier 2. This will healthcare and emergency services, complex and/or high-risk settings such as care homes, schools, prisons/places of detention, workplaces, health care facilities and transport where it hasn’t been possible to identify contacts. Advice following national guidance will be given to cases, their close contacts and settings/communities as appropriate. Hard to reach cases are referred onwards to the LA’s local Test and Trace services for further investigation.

For the Kent and Medway localities, Tier 1 contact tracers are the PHE HPT available at ICC.kent@phe.gov.uk or 0344 225 3861. As outlined in Section 7 and Figure 3, complex cases can be referred to PHE HPT contact tracers via several routes:
1. A positive case is identified by Tier 2 & 3 of NHS T&T to be complex or within a complex setting.
2. Through direct notification from a complex setting to the PHE HPT regarding either a symptomatic or confirmed positive case.

In addition, there is the NHS T&T App, which has been designed to work alongside the traditional tiers of contact tracing services detailed above. Contact tracing through the App works by detecting and logging other nearby App users. If any of those users later test positive for COVID-19, any other users who have recently been in close contact will receive an alert advising them to isolate. Local businesses have been asked to support this aspect of contact tracing by creating and displaying an NHS T&T QR code for their venue.

MC and KCC will also be delivering a locally supported contact tracing service in association with the wider national NHS T&T programme. If the national NHS T&T team cannot contact a Medway or Kent resident who has tested positive for COVID-19 within the first 48 hours of receiving a result, they are then then passed to the councils’ contact tracing team, who will use local data and community knowledge to follow up. This will allow a more tailored approach to contact tracing and supporting local residents.

### 7.2. Outbreak Definition & Plan Activation

An outbreak is defined as two or more cases (suspected and/or confirmed) linked in place and time [33]. The LOCP may therefore be triggered when there are suspected or confirmed COVID-19 outbreaks in any setting type. It should be noted that most outbreaks will be managed through business as usual measures.

The LOCP will also be triggered when there is clear indication of community spread of the virus locally (i.e. a rising tide situation where either a number of different locations flagging or there are a number of community cases with no obvious immediate links between them, especially if take alongside increasing incidence rates) or the additional capabilities of the SCG may be needed

LOCP initiation may also be informed by national government direction in the form of Local COVID Alert Levels, a three-level system for monitoring and responding to COVID outbreaks within the local community that matches the restrictiveness of infection control strategies to local case
numbers.

The LOCP and its relevant mechanisms will only be activated following appropriate risk assessment and discussion between agency partners (as detailed in section 7.3)

7.3. Outbreak Response

In the event of an outbreak occurring in a particular setting, the steps listed in Table 2 will be taken. A summary overview of the outbreak response within a defined setting can be found in Figure 3. In the event there is indication of community spread of the virus (as defined in Section 7.2) required the steps listed in Table 3 will be taken.

These steps may vary slightly depending on the situation and circumstance of the outbreak and will be tailored to the nuances of each situation drawing on local intelligence (see Section 8). This is in line with the LA PHE Joint Action Plan SOP (and the National Government’s Contain Framework [34]
**Table 2 – Steps to be Taken in Response to an Outbreak within a defined setting (e.g. school, care home)**

<table>
<thead>
<tr>
<th>STEP 1 – Initial Risk Assessment &amp; Contact KCC/MC Single Point of Contact (SPOC)</th>
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<tbody>
<tr>
<td>After being alerted of new outbreaks, the PHE HPT will contact the relevant setting to ensure all actions have been taken by the setting in question to identify contacts and manage any ongoing risk of transmission in line with national guidance. The PHE HPT will provide public health advice either by email or verbally. They would then conduct a risk assessment to determine the complexity of the situation and whether further measures may need to be taken. If it is decided that additional support may be required, PHE HPT will inform the relevant DPH by email or phone via the existing emergency planning route. Together they will have a joint discussion to develop a deeper understanding of what caused the issue, identify possible solutions and the next steps to be taken. Based on the outcomes of the expert risk assessment and these discussions, the DPH and PHE HPT will also decide whether it is necessary to convene an Outbreak Control Team (OCT).</td>
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<table>
<thead>
<tr>
<th>STEP 2 – Infection Control &amp; Response to Enquiries</th>
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<tbody>
<tr>
<td>If it is decided that an OCT should be convened, PHE HPT and the DPH will identify and contact key stakeholders to form the OCT. The OCT will be responsible for agreeing the outbreak response plan moving forward including deciding the roles of the multi-agency response, the measures they will take and what resources will be required to deliver the response. The relevant members of the OCT would also follow up with the setting’s occupational health departments or other points of contact and support the affected setting on operational issues (e.g. sourcing PPE, staff capacity, removal of dead bodies &amp; care provision). Any situation updates will be fed back to the Health Protection Board, a multi-agency meeting led by the Public Health Departments of both counties and incorporating stakeholders from the local Public Health England Health Protection Team, the 12 district and borough council Environmental Health teams, the Kent Resilience forum, the local CCG and other key decision-making partners. This Board meets weekly to provide strategic oversight for Kent and Medway’s local outbreak control plan and address key challenges to curbing transmission rates.</td>
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<tr>
<th>STEP 3 – Perform Enhanced Testing &amp; Contact Tracing</th>
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<tbody>
<tr>
<td>Testing of people within complex settings may be advised by the OCT. Testing will be done in collaboration between the local authority, PHE and the DHSC, including mobilising existing Mobile Testing Units where necessary. KCC and MC may need to supplement testing and contact tracing efforts through NHS mutual aid, mutual aid from environmental and public health teams at district) and borough councils, external partners who have undergone training (see Section 6.3).</td>
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<thead>
<tr>
<th>STEP 4 – Continue to Monitor Intelligence</th>
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<tr>
<td>The setting will continue to be monitored by the OCT closely using regular intelligence updates as detailed in Section 8.</td>
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<tr>
<th>STEP 5 – Facilitate Closures and/or Targeted Restrictions of that Setting</th>
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<tbody>
<tr>
<td>If the virus continues to spread, activities at that setting may be restricted or required to close (see Section 3.1). This will be decided by the OCT based on a risk assessment. Additional multi-agency national incident resources will be deployed to bolster local resources to respond to the incident if necessary. Special powers may also need to be invoked, depending on the resistance that is put up by the setting or persons required to isolate. There are several that can be utilised</td>
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</table>
so the OCT will need to determine the most appropriate. If any legislative powers are used, the DPHs are required to notify the Secretary of State as soon as reasonably practicable after the direction is given and review to ensure that the basis for the direction continues to be met, at least once every 7 days.

Table 3 Steps to be taken in response to the community spread of COVID-19 (i.e. rising tide scenario)

<table>
<thead>
<tr>
<th>STEP 1 – HPB Monitors Intelligence</th>
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<tbody>
<tr>
<td>The HPB continuously monitors the local situation and through intelligence and situation reports presented at the weekly meeting. The KRF COVID-19 Enforcement Cell will also review, and risk assess any upcoming events against this for recommendation for approval (see Section 8).</td>
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<table>
<thead>
<tr>
<th>STEP 2 – Indication of Community Spread and Decision to Convene an ICT</th>
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<tr>
<td>If there is indication of community spread of the virus (see Section 7.2) or where it looks like the capabilities of the SCG may be required, then the HPB will convene an ICT. The DPH would invite key members and stakeholders to the ICT including representatives from the KRF SCG.</td>
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<table>
<thead>
<tr>
<th>STEP 3 – Role of ICT &amp; Facilitation of Enhanced Restrictions/Closures/IC Measures</th>
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<tr>
<td>The ICT will allow for dedicated time to discuss the situation, gather more detailed intelligence, and decide what additional communicable disease control measures may need to be put in place. The ICT will need to anticipate and respond early as any measures taken will take several weeks to have an effect. They may therefore start by implementing some smaller targeted IC measures and restrictions early on – especially in response to soft intelligence e.g. police reporting raves, no mask wearing.</td>
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Depending on the prevalence of cases within that LA, the ICT may also decide to encourage people in the community to get tested. KCC and MC may need to supplement testing and contact tracing efforts through NHS mutual aid, mutual aid from environmental and public health teams at district and borough councils, external partners who have undergone training (see Section 6.3).

All decisions made should be in partnership/consultation with people in the community and settings who would be affected. Any situation updates will be fed back to HPB.

<table>
<thead>
<tr>
<th>STEP 4 – Escalate Concerns &amp; Facilitate Move to a Higher COVID-19 Alert Level</th>
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<tr>
<td>If all previous measures taken are unable to stop the spread of the virus within the community or the scale/type of outbreak calls for the use of wider or more intrusive powers, then decision-making may be escalated to the national level. Escalation to this point may be requested by LAs themselves or come at the direction of the national government.</td>
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In this instance, the decision may be made to move the LA area to a higher COVID-19 alert level. An outline of the main restrictions that apply at each level is described below:
‘Medium’ alert level (Level 1) – This is the lowest level of restrictions and currently covers most of the country – here measures include the Rule of Six and the closure of hospitality at 10pm. People are advised not to travel into a Tier 4 area.

‘High’ alert level (Level 2) – This will reflect many current local interventions but will apply much-needed consistency to response in these situations. Here, household to household transmission will be prevented by banning all mixing between households or support bubbles indoors and The Rule of Six is applied in outdoor spaces, including private gardens. People are advised not to travel into a Tier 4 area.

‘Very High’ alert level (Level 3) – This will be applied in areas where transmission, hospital admission and growth rates – especially amongst vulnerable groups - are causing great concern. People are not advised to travel in and out of Level 3 areas and local bars and pubs must close unless they are operating in a restaurant capacity (serving substantial meals). These restrictions, and indeed the criteria set for each alert level, are subject to change. People are advised not to travel into a Tier 4 area.

‘Stay at Home’ alert level (Level 4) - This will be applied in areas where transmission, hospital admission and growth rates are causing the greatest concern. People living in Tier 4 areas are advised to stay in their homes except for reasonable excuses such as work and education purposes. People are advised not to meet other people indoors, including over the Christmas and New Year period except if one lives with them or are part of a support bubble. Outdoors, one can only meet with one person from another household.

In addition to this, national government will work with local leaders on a case-by-case basis to determine if there should be additional bespoke restrictions and measures should be implemented that go beyond this baseline – this may include the closure of gyms, casinos and leisure centres or the resumption of shielding, and the accompanying support, for clinically vulnerable residents within that area. Non-essential retail, school and universities will remain open in all levels, however. These measures will be kept under constant review, including a four-week sunset clause for interventions in ‘very high’ areas. More information on the specifics of this new alert system can be found here. Helpful posters that differentiate restrictions across the three levels can be found here.

Any decision about alert levels and further bespoke restrictions will involve discussion with county members, district members and MPs, and will need to ensure that this is balanced with being able to maintain engagement of the population over the long term and consider the wide geography and difference in situation between areas.

If a tactical response is required then, the KRF SCG will be stood up (see Section 7.4) and additional multi-agency national incident resource will be deployed to bolster local resources to respond to the incident.

Although the government has instated a national lockdown in England between November 5th and December 2nd, the intention is to reinstate local COVID-19 alert levels after this time.
Figure 3 – Referral Routes of Cases in Complex Settings to the PHE HPT and the Required Responses. The different routes by which a positive or suspected case of COVID-19 in a complex setting can be referred to the PHE HPT. BLUE boxes = testing facilities that are part of the NHS T&T system and results are therefore automatically fed through to PHE CTAS. GREEN boxes = testing facilities that may need to manually notify PHE HPT of a positive test result to ensure timeliness of notification.

7.4. Decision to Escalate and Stand Up KRF SCG

The decision to escalate and stand up the SCG will be scenario dependent and will need to account for a variety of factors rather than any single trigger. This decision will most likely be in response to a scenario whereby there is a sustained increase in positivity rates and/or case numbers that are not being managed by standard infection control measures and which look to result in enhanced infection control and/or supportive measures being put in place within a particular area.

An OCT or ICT (see Table 3) would be responsible for making the final decision about whether to escalate and stand up the SCG (if not already stood up). This decision would usually occur in tandem with the decision to escalate to the Chief Executive of the affected Local Authorities.

The DPH and/or SCG members of the ICT (if applicable) would stand up (or inform if already stood up) the KRF SCG via the procedures outlined in the KRF Pan Kent Strategic Emergency Response Framework. Other KRF cells, such as the KRF COVID-19 Vulnerable People and Communities Cell, may also need to be activated by the KRF SCG. The KRF SCG will ensure all activities, including COVID-19 response updates, are then communicated to local, regional and national partners as well as other key stakeholders via the KRF - Media & Communications Cell. If the KRF SCG decides an operational response is required, they will communicate this to the KRF TCG who will coordinate the response as detailed in the KRF Pan Kent Strategic Emergency Response
To ensure partner agencies have oversight and are fully informed of any upcoming situation, the following communication channels are also in place; (i) a weekly HPB meeting (ii) regular TCG meetings on which KCC and MC public health representatives sit (iii) a twice weekly HSCC meeting on which TCG representatives sit (iv) regular SCG Chairs meetings on which the DPHs sit.

7.5. Infection Control

There are additional measures and support mechanisms in place through KCC and MC to help complex settings in the region prevent the spread of COVID-19. National guidance on preventing the spread of infection in specific settings can be found in setting specific action cards located in the Appendix and covers social distancing, hand hygiene, PPE, isolation and enhanced cleaning measures.

If there are debilitating shortages, eligible health and social care providers within Kent and Medway can also order PPE through this dedicated government portal.
8. Theme 6 - Data Integration & Analytics

This section should be read in conjunction with Sections 4.1 & 7.3. There are a number of local, regional and national data sources available to the HPB’s members and its partners in establishing and mitigating COVID-19’s spread in Kent and Medway. This section details the; (1) objectives of data integration & analytics, (2) data sources & arrangements, (3) data integration & (4) information governance.

8.1. Objectives

The available data will be used to:

- Review daily data on testing and tracing;
- Identify complex outbreaks so that appropriate action can be taken in deciding whether to convene an outbreak control team (see Section 7.3);
- Track relevant actions (e.g. care home closure) if an outbreak control team is convened;
- Identify epidemiological patterns in Kent and Medway to refine our understanding of high-risk places, locations and communities;
- Ensure that those who require legitimate access to the intelligence for different purposes can do so, regardless of organisational affiliation, whilst ensuring information governance and confidentiality requirements are met.

8.2. Data Sources & Arrangements

The PHE HPT, PHE – Epidemiology Cell, JBC, MAIC, and Kent and Medway CCG – Modelling Group are all responsible for providing and overseeing two or more types of data reports. In addition, details on the sources of information regarding vulnerable people can be found in the KRF Identifying & Supporting Vulnerable People Plan which is available from Resilience Direct.

8.3. Data Integration

One of the key themes of local government planning is integrating national and local data and scenario planning through the JBC Playbook (e.g. data management planning including data security & data requirements including NHS linkages). This requires cross-party and cross-sector working via the KRF, NHS Integrated Care Systems and Mayoral Combined Authorities. All enquiries regarding this should go to england.riskstratassurance@nhs.net.

The JBC COVID-19 Outbreak Management Toolkit for England states that according to the risk level within an area based on key metrics, there will be different guidance on how to provide Non-Pharmaceutical Interventions. To determine the risk level, both quantitative and qualitative data will be utilised with Table 4 stating the threshold of each risk level.

This data is however not granular or timely enough to inform a system management approach to COVID-19 outbreak management. Therefore, as part of the delivery of the LOCP, the HPB are currently developing a regular situation report (SITREP) that will involve the amalgamation of several data sources. This will assist in;
1. **Early warning and surveillance** – to identify potential outbreaks / clusters that may be discernible by time, place (i.e. workplace setting, residence), location

2. **Scenario forecasting and simulation modelling** – to inform us how these outbreaks may have an impact on Kent and Medway’s wider health and care systems (e.g. hospital admissions and deaths management)

### 8.4. Information Governance

Ordinarily, due to the sensitive nature of the health information being shared across local organisations, Kent and Medway LAs would set up data recording and sharing agreements in line with General Data Protection Regulation (GDPR). These arrangements allow for collaborative data sharing between NHS colleagues, PHE partners and Kent and Medway LAs. Applications would also be made for ‘Section 251 support’ from the Confidentiality Advisory Group for the sharing of information without consent for research and non-research activities.

However, in emergency response situations, permissions under the Civil Contingencies Act 2004 [27] requires Category 1 & 2 responders to share information with each other as they work together to perform their duties under the Act. Further guidance was provided by the *Data Protection and Sharing – Guidance for Emergency Planners and Responders (2007)*, published by the Cabinet Office. Its purpose was to inform organisations involved in the preparation for, response to, and recovery from emergencies on when they can lawfully share personal data under data protection legislation. This has subsequently been replaced by the *Data Sharing in Emergency Preparedness, Response and Recovery* guidance which, as of June 2020, is out for consultation.

In addition, the Secretary of State for Health and Social Care has issued a general notice under the Health Service Control of Patient Information Regulations 2002 [34] to support the response to COVID-19. This allows NHS Trusts, LAs, and others to process confidential patient information without consent for COVID-19 public health, surveillance, and research purposes. The notice is currently in force until 30th September 2020 and provides a temporary legal basis to allow a breach of confidentiality for COVID-19 purposes. Agencies should therefore assume they are able to adopt a proactive approach to sharing the data they need to respond to COVID-19.

This approval applies to the use of GP and Secondary Care data but does not cover disclosure of social care data for risk stratification. Where social care data are to be used, then the relevant parties will need to assure themselves of a legal basis for the disclosure and linkage of data for this purpose. This will be achieved either by using third party and pseudonymised data, or with consent.

Finally, the *Kent and Medway Information Sharing Agreement* is an agreed inter-agency information sharing protocol that is available for all organisations within Kent and Medway and includes sharing information during incident response.
### Table 4 – Joint Biosecurity Centre Risk Level Thresholds

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Quantitative</th>
<th>Qualitative</th>
</tr>
</thead>
</table>
| Low        | • Average (seven day) daily new positive confirmed cases of COVID19 is <1 per 100,000 resident population  
  • Average (seven day) daily new hospital admissions of COVID19 is <0.1 per 100,000 resident population  
  • Contact tracing teams are tracing & advising to isolate 80% or more contacts within 48 hours.  
  • Continuous monitoring of trends in local measures show low-risk | • There is no data or intelligence reports suggesting an outbreak in the area.  
  • There are no identified additional concerns about socially vulnerable populations, clinically vulnerable populations, or hard to reach groups. |
| Medium     | • Average (seven day) daily new positive confirmed cases of COVID19 is 1 to 10 per 100,000 resident population  
  • Average (seven day) daily new hospital admissions of COVID19 is 0.1 to 1 per 100,000 resident population  
  • Contact tracing teams are tracing & advising to isolate 70% or more contacts within 48 hours.  
  • Continuous monitoring of trends in local measures show medium risk | • Multiple outbreaks (5 to 10) are identified in low to medium risk settings, which are contained to those settings and a small geographic area  
  • There are very small concerns or outbreaks in socially vulnerable populations, clinically vulnerable populations, or hard to reach groups. |
| High       | • Average (seven day) daily new positive confirmed cases of COVID19 is >10 per 100,000 resident population  
  • Average (seven day) daily new hospital admissions of COVID19 is >1 per 100,000 resident population  
  • Contact tracing teams are tracing & advising to isolate 70% or less contacts within 48 hours.  
  • Continuous monitoring of trends in local measures show high-risk | • Multiple outbreaks (5 to 10) are identified in medium to high risk settings and multiple geographic areas. Local teams are unable to effectively respond to the outbreak.  
  • There are outbreaks in socially vulnerable populations, clinically vulnerable populations, or hard to reach groups; which requires local teams to gain further resources to contain the outbreak. |
9. Theme 7 - Supporting Vulnerable Populations

This section details the support provided to Kent and Medway residents at risk of COVID-19 and/or their impacts. In Kent and Medway, the KRF COVID-19 Vulnerable People and Communities Cell has oversight of the arrangements in place to support vulnerable populations.

These populations may have increased vulnerability due to any combination of the following factors:

1. Socially vulnerable and impacted by restrictions including the requirement to self-isolate
2. Those at higher risk of transmission
3. Those at higher risk of death from COVID-19

Their needs may be far reaching and include:

1. Enhanced communication of transmission risks and public health advice,
2. Help accessing testing,
3. Financial, food and/or housing support &
4. Support with mental and physical healthcare.

Public Health England has released an array of action cards to support reporting outbreaks in different sectors and sensitive settings. These can be accessed here. In addition, those looking to learn about Kent and Medway’s own efforts to support vulnerable populations should refer to the KRF Identifying & Supporting Vulnerable People Plan which is available from the Resilience Direct upon request. This may need to be reactivated in the event of a local lockdown (see Section 7.3). Please refer to Section 8 and 10 that describe the data analytics and communications strategies specific to these populations.
10. Theme 8 - Communication & Engagement Strategy

To ensure the impact of COVID-19 in Kent and Medway is minimised, it is crucial that there are clear communication lines between key stakeholders and the general public. There are already several well-established internal communication channels between working groups and committees involved in Kent and Medway’s COVID-19 planning and response (see Section 7.4). This section therefore outlines the Kent and Medway communications and engagement strategy for the; (1) public (2) complex settings (read in conjunction with Section 5 & 7) & (3) voluntary organisations (read in conjunction with Section 9).

10.1. The Public

Communication and engagement with the public during a major incident will generally be coordinated by the KRF SCG in a manner that is consistent with the KRF Media & Communications Plan.

This comprises of;

1. Wider public warning and informing messaging including:
   - Scam or fake news and messaging relating to COVID-19
   - Scam or fake news and messaging relating to COVID-19 Vaccine
   - Identified outbreaks in their local area
   - Implementation of local outbreak control measures

2. Communications campaigns pertaining to the latest government advice & guidance including:
   - Understanding where to access information regarding COVID-19
   - Understanding the importance of testing and where to get tested
   - Understanding the importance of vaccination and where to get vaccinated
   - Understanding the requirements and rationale for self-isolation of asymptomatic contacts
   - Data privacy assurance that their personal information will be held in the strictest confidence & will not affect matters such as immigration status or reveal illegal activities.
   - Awareness of local and national support that is available
   - Correct usage of facemasks and handwashing

The KRF SCG will especially consider how this information is communicated to vulnerable populations such as high-risk groups (BAME, shielders), marginalised groups (homeless, gypsy roma and traveller communities) or those that may experience barriers to accessing updates (learning disabilities) to ensure they are reached alongside communicating any population specific guidance.

The KRF SCG will use a range of methods to ensure information is distributed in a timely manner. They will work together with the KRF COVID-19 Vulnerable People and Communities Cell to ensure they reach vulnerable populations. They will also leverage existing relationships with community and faith leaders alongside digital engagement tactics such as targeted advertisement for areas with high infection rates using social media.
In addition, the LOEB will play an essential role in ensuring a two-way process of communication. They will empower the public and businesses to share the challenges and opportunities they have experienced through implementing COVID-19 measures, allowing for learning.

It is also critical that media and news outlets are provided with timely and accurate advice, information, and formal statements. The media team will be responsible for monitoring and managing all information obtained from and provided to the media by KCC & MC.

10.2. Complex Settings

KCC & MC already have strong, well-established communications with complex settings identified in Section 5

10.3. Voluntary and Community Sectors

Kent and Medway’s voluntary and community sector organisations are delivering a wide offer to advocate for and meet the needs of Kent and Medway residents via the KRF COVID-19 Vulnerable People and Communities Cell who will build on existing relationships with these organisations to communicate how to;

1. Identify the needs and provisions of the local population
2. Build support and workforce capacity to respond to increases in need
References


Appendix 1 – Care Homes

Including
Residential Homes, Nursing Homes, Supported Living Settings, Extra Care Settings, Domiciliary Care, Learning Disabilities Settings (homes and day care units), Physical Disabilities Settings and Mental Health Settings (for NHS settings, please also see Appendix 3).

Objective
The objective is to identify new cases of COVID-19 early, control the spread of the virus and reduce deaths from COVID-19 in care homes in Kent and Medway.

Context:
There are 613 CQC registered adult care homes in Kent and Medway.
The ownership types include:
- 496 privately owned
- 104 voluntary/non-for-profit
- 1 NHS service
- 12 local authority owned

The type of care homes includes:
- 489 Residential homes (care only)
- 124 Nursing homes (care home with nursing)

What’s already in place:
All partners within the HSCC have worked closely with several partner organisations to implement a package of measures to support care homes in Kent and Medway to prevent and respond to outbreaks, including:
- PHE has a robust outbreak management plan for use in care homes
- British Geriatrics Society has released a good practice guide for COVID-19: Managing the COVID-19 pandemic in care homes for older people
- The NHS has offered training in infection control for care home staff
- Care homes advised to stay away from using misting devices in the prevention of COVID-19 as they are not advised by SAGE and have no role in infection prevention and control
- The NHS has committed that all care homes will be supported via primary care and community support
- The UK Government is offering all care homes a support package
- Care homes with residents who have a certain degree of frailty have access to ‘extra-care schemes’ support
- Care home outbreaks are to be managed through Pillar 1 testing; Supporting Living settings will receive test kits in batches of 10 and Extra Care settings will receive test kits in batches of 40.
- Eligible care homes staff and residents will also receive regular asymptomatic testing including agency staff and volunteers (staff every 7 days and residents every 28 days) via
Pillar 2 testing. Care homes can register for this via the government digital portal

As of 22nd July 2020, DPHs in at KCC and MC will assess the level of community transmission and national oversight in their area and announce whether care homes locally are able to consider allowing visitors; DPHs should refer to The Capacity Tracker a timely and rich source of transmission data in each locality. The DPH in every area should disseminate their view on the suitability for visiting in the local authority area. The final decision of whether to permit visitation, to what extent and in what circumstances is then for the provider and managers of each individual care home to make. All decisions must also take into consideration the legal obligations under the Equality Act (2010) and Human Rights Act (1998) that both DPHs and care providers are beholden to.

Each care home is responsible for developing a visitation policy, and undertaking a dynamic risk assessment following the guidance set out here. They should consider the significant vulnerability of their residents, their outbreak status, their readiness as an organisation and ensure strict infection control measures are in place, including face coverings for all visitors. As we approach the winter months ahead, tightened prevention and control measures have been drawn up within the Adult Care Social Plan (linked below) to enable these visits to continue safely and at local discretion.

To limit risk, where visits are permitted to go ahead, these should be – wherever possible - limited to a single constant visitor per resident. To support providers, the Care Provider Alliance have published a sector-led protocol for enabling visiting based on this model and infection-control precautions are listed in full on the government site linked above. Each care home’s visitation policy should be made available and/or communicated to residents and families to prepare visitors before each visit. Friends and family members must also be made aware that visitation policies are subject to change in accordance to the verdicts of dynamic risk assessments.

If a care home suspects a case or in the event of an outbreak, the home should rapidly impose visiting restrictions and follow the outbreak process outlined below. If there is evidence of further spread of the virus in the local community, DPHs will inform the relevant care homes and visitation will also be stopped. If an individual or group of care homes is/are in need of restricting visitation, either temporarily or permanently, it is the DPH’s responsibility to communicate this in writing to commissioners of all care homes implicated in a timely fashion or – in the absence of a commissioner – direct to the registered manager.

When it is determined that in-person visitation is not appropriate, care homes should support visiting in virtual manner however they can. The onus is on the care homes themselves to provide regular updates to residents’ loved ones on their mental and physical health and how they are coping.

What else will need to be put in place:
- Antibody testing is soon to be rolled out to care homes, booking systems to be set up.
- Asymptomatic testing in domiciliary care settings is contingent on the results of the PHE prevalence study (which is due shortly) and the success of rapid testing pilots.
- Asymptomatic testing for extra care and supported living settings is still to be decided.
- Testing arrangements for individuals prior to a new care home admission or transfer to another care setting (excluding hospital) still need to be put in place.
- Rapid testing options will soon be available for care homes.
- A children homes SOP is currently in development which incorporates established processes and procedures to ensure staff are aware of how to access testing for symptomatic children and how to respond to an outbreak.

Communication:
- Communication to raise awareness of widespread community transmission (NHS ‘Talking Heads’) and encourage people to see their loved ones but stressing that these are settings with vulnerable people.

**Local outbreak triggers & process:**
An outbreak in a care home is suspected if there are 2 or more confirmed positive cases of COVID-19 within 14 days of each other. In this instance, the setting should undertake an immediate risk assessment to identify close contacts of confirmed cases and ensure that the setting is COVID-secure.

If this outbreak has occurred in a domiciliary care setting, the registered manager should notify the council (specifically the commissioning team) all staff who have come into close contact with the infected individual(s) and – if the patient has recently been discharged from hospital – the relevant NHS infection control team. Those who have come into close contact with an infected individual should only pursue testing if they develop symptoms – they should begin self-isolation immediately after being contacted, however.

This is considered a complex setting under the remit of Tier 1 PHE HPT contact tracers. Therefore, in the event of an outbreak, all visitation should be stopped and the PHE HPT should be contacted immediately.

PHE HPT will then:
- Conduct a situation assessment. Investigations should include testing as per the request or advice of the PHE HPT, clinicians or GP that has attended and reviewed the case.
- If the outbreak has occurred in a domiciliary care setting, an enhanced risk assessment process will be triggered; an OCT is only arranged in this setting if there is a considerable risk of secondary spread in the community.
- If there is a suspected outbreak after conducting investigations, PHE HPT will provide advice on infection prevention and control. Care homes should also complete the [Immediate Infection Control Checklist](#).
- The HPT will then order a batch of tests for rapid testing of the whole care home (residents and staff) on day 1 through the local Pillar 1 testing capacity. This should then be repeated.
on day 4-7 for all staff and residents who initially tested negative to reduce the false negative risk

- PHE HPT will consider the outbreak’s spread and severity, current control measures, the wider context and will jointly consider with KCC/MC the need for an OCT.
- Re-testing after 28 days from the last suspected case will be provided through Pillar 2 to confirm the outbreak has ended.
- Where staff members work in multiple locations, they must be tested immediately before their shift at the care home.
- Under Tier 4 guidelines which currently applies to Medway and Kent, there will be a rapid response to a single positive COVID-19 result (from either staff or resident) through daily staff testing at the start of a shift for 7 days.
- Once the outbreak is confirmed over, if an area is closed to admissions, the criteria for reopening as a minimum should be; (1) no new symptomatic cases for a period of 14 days, (2) existing cases to be isolated/cohorted and symptoms should be resolving, and (3) there should be sufficient staff to enable the facility to operate safely. If staffing capacity is affected by the outbreak (e.g. team members having to take time off work to self-isolate) then team members are encouraged to work in small units – or bubbles - with specific service users.
- While PHE HPT does not routinely follow-up after an outbreak has ended (unless there is a sudden escalation in cases or multiple deaths have occurred), councils do have follow-up protocols to facilitate a care setting’s return to normal operations.

**Resource capabilities and capacity implications:**

**Staffing**

- Additional infection prevention and control training and support for care homes with outbreaks

**PPE**

- Ongoing provision of PPE until care homes can source PPE through normal supply routes or the PPE portal for small care homes (less than 24 beds)

**Links to additional information:**

- Coronavirus (COVID-19): Adult Social Care Guidance
- Apply for Coronavirus Tests for a Care Home
- BGS COVID-19: Managing the COVID-19 pandemic in care homes for older people
- Update on policies for visiting arrangements in care homes
- Management of staff and exposed patients/residents in health and social care settings
- The Adult Social Care Winter Plan
Appendix 2 – Schools, Early Years & Other Educational Settings

**Including:** Primary and secondary, early years, SEND, day cares, nurseries, alternative provisions for schools, school transportation, boarding schools, further education, foster homes

**Objective:** To identify new cases of COVID-19 early, control the spread of the virus and enable all educational and early years settings in Kent and Medway to fully reopen.

**Context:**
In Kent and Medway, there are:
- 829 Childminders
- 31 Academy Nursery
- 10 Creche
- 273 Day Nursery
- 49 Holiday Club
- 54 Home Childcare- Registered Nanny
- 35 Maintained Nurseries
- 43 School Nurseries
- 34 Nursery Units of Independent Schools
- 93 Out of School Club
- 301 Parent and Toddler Group and preschools
- 41 Private Nursery School
- 662 Primary Schools
- 221 Secondary Schools
- 190 16 to 18 schools/colleges
- 22 Special schools
- 58 Independent schools
- 4 Universities
- 20 Ofsted registered children homes

**What’s already in place:**
As schools have reopened, procedures have been put in place to reduce risks to staff and pupils including:
- A dedicated Department of Education (DfE) helpline to support schools in times of lockdown and tiered alert levels
- PHE has a SOP for the management of school outbreaks and there is substantial national guidance for how to operate schools during COVID-19.
- Priority access to testing is available to all essential workers and their households. This includes anyone involved in education, childcare or social work - including both public and voluntary sector workers, as well as foster carers. Essential workers, and those who live with them, can book tests directly online.
- In Medway, Public Health support around COVID-19 related issues are given to schools via the weekly Head Teachers reference group
- Universities have been asked to develop a COVID-19 outbreak plan
● Local test sites have been set up on-site of University Campuses in both Canterbury and Medway. These are accessible on foot.
● The government recently released detailed guidance on apprenticeships and other early careers opportunities for apprentices, employers, training providers and assessment organisations; this can be accessed here.
● Government guidelines on how to reduce risk of COVID transmission in playground settings can be found here.
● Updated government guidelines on how to go about safely reopening higher education buildings and campuses can be found here.

What else will need to be put in place:
● KCC and MC are developing a SOP which will incorporate established processes and procedures to ensure schools, parents, county councils, and healthcare colleagues are aware of how to access testing for symptomatic people and how to respond to an outbreak.
● From January, staff and students in secondary and college level will have access to regular testing to help keep them in school and college from the start of spring term (attach schools and college handbook here for ref.)
● Tests will be available weekly to all staff and students in secondary and college level
● Tests will be available daily for close contacts, preventing the need to self-isolate unless testing positive
● Testing to be scaled up to reach all school and college staff and students over spring term

Local outbreak triggers & process:
From Thursday 17 September, there will be a new advice line available to nurseries, schools and colleges who have been informed of a confirmed case(s) of coronavirus in their setting (i.e. a pupil or staff member testing positive).

Instead of calling the PHE HPT when there is a confirmed case, the education settings above are now asked to call the DfE’s helpline on 0800 046 8687 and select the option for advice following confirmation of a positive case. The line will be open Monday to Friday from 8.00am to 6.00pm, and 10.00am to 4.00pm on Saturdays and Sundays. DfE will be responsible for escalating these cases as necessary to PHE HPT following a triaging of each school’s circumstances. More details about this service can be found here

This new advice service has been set up to advise the following education settings: early years including nurseries, schools including primary, infant and junior schools, middle schools, secondary schools and further education colleges.

If the education institution does not fall under one of these settings (e.g. University), they should instead contact their local PHE HPT directly if several staff members or students staff or have received a positive test result and there is reason to believe there is an outbreak.

An outbreak in an educational setting is suspected if there is either:
● Two or more confirmed cases of COVID-19 among pupils or staff in a setting within 14 days or;
• An increase in pupil absence rates, in a setting, due to suspected or confirmed cases of COVID-19

The PHE HPT will undertake a risk assessment and conduct a rapid investigation and advise on the most appropriate action to take. This process will be heavily based on school’s own risk assessments; these are crucial for identifying close contacts and ensuring that measures are in place to reduce the likelihood that further cases might occur. School-led risk assessments must consider cleaning and waste management protocols and lines of communication to staff and parents in the event of escalating cases.

Depending on the risk assessment outcome and the scale of the outbreak, the PHE HPT and KCC/MC may establish an OCT to help manage the situation. The OCT will lead the Public Health response and investigations and put appropriate interventions in place. This may include decisions around closure; this is rarely needed to control an outbreak and should only be done following advice from the PHE HPT and in discussion with KCC/MC and the Regional Department of Education REACT team.

When a child, young person or staff member develops symptoms compatible with COVID-19, they should be sent home and advised to self-isolate and arranged to be tested; unless mass testing has been rolled out in the educational setting in question, testing should not be pursued if a person does not have symptoms of COVID-19. Those who are living in on-campus accommodation and who are required to self-isolate must not vacate their accommodation until their period of self-isolation has come to an end or they are told otherwise.

Schools are to obtain PPE from procurement lines and refer to the Education Department for government PPE support prior to requesting KRF support.

All Universities have identified a SPOC for COVID-19 related enquiries.

<table>
<thead>
<tr>
<th>Resource capabilities and capacity implications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A KCC/MC SOP on supporting when an outbreak among staff has been identified and control measures need to be implemented</td>
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<table>
<thead>
<tr>
<th>Links to additional information:</th>
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<tbody>
<tr>
<td>• <a href="https://www.gov.uk/government/publications/actions-for-education-and-childcare-settings-to-prepare-for-wider-opening-from-1-june-2020">Actions for education and childcare settings to prepare for wider opening from 1 June 2020</a></td>
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<tr>
<td>• <a href="https://www.gov.uk/government/publications/coronavirus-travel-guidance-for-educational-settings">Coronavirus: travel guidance for educational settings</a></td>
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</tbody>
</table>
● Supporting children and young people with SEND as schools and colleges prepare for wider opening
● Planning guide for early years and childcare settings
● Actions for early years and childcare providers during the coronavirus outbreak
● Protective measures for holiday or after-school clubs and other out-of-school settings for children during the coronavirus (COVID-19) outbreak
● Guidance for parents and carers of children attending out-of-school settings during the coronavirus (COVID-19) outbreak
Appendix 3 – Health and Social Care Settings

Including: GPs, Birthing centres, Mental health Trusts, Acute trusts, Community Health Trusts, Dentists, Child health Services, Ambulance, Social Work & Home visits (for care homes see Appendix 1)

Objective: The objective is to closely monitor any cases of COVID-19 linked to exposure within Primary Care settings, Mental Health and Community Trusts ensuring that any outbreaks are managed quickly and efficiently.

Context:
In Kent and Medway, there are:
- 382 GPs
- 342 Pharmacies
- 429 Dentists
- 24 Hospitals
- 1 Mental Health Trust
- 2 Community Health Trusts
- 4 Acute Trusts (including 3 Foundation Trusts)
- 1 Ambulance Service

There are also local social work, home visit & child health services available for residents.

What’s already in place:
- PHE has a dedicated SOP for controlling outbreaks in this setting and ample government guidance is available online.
- All NHS Trusts have outbreak management plans to support in identifying and escalating new suspected cases of COVID-19
- It is now compulsory for the council to display signage warning that masks must be worn on the premises in all council-owned or managed buildings.
- SOP for GP surgery is released by the NHS and Royal College of General Practitioners guidance for GPs are provided on their website.
- SOP for Community Pharmacy is released by the NHS
- SOP for dental practice on urgent dental care and phased transition are released by the NHS.
- SOP for community health services is released by the NHS
- Legal guidance for mental health, learning disabilities and specialised commissioned mental health services is released by the NHS.
- Information for ambulance services can be found on the designated page of the NHS website.
- Infection control, PPE, clinical waste and environmental decontamination guidance are available on the designated page of the NHS website.
- Updated government guidelines on how to support those who lack mental capacity during the pandemic can be found here.

What else will need to be put in place:
General Practices and Walk-in Centres
- Antibody testing for staff and patients
<table>
<thead>
<tr>
<th><strong>Community Pharmacy</strong></th>
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<tbody>
<tr>
<td>● Funding to support a locally commissioned service for delivery of medicines (in the event of the national pandemic pharmacy delivery service having ended)</td>
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<tr>
<td>● Consider prioritisation of pharmacy staff within key services e.g. school places, access to other essential services</td>
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<thead>
<tr>
<th><strong>Mental Health and Community Trusts</strong></th>
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<tbody>
<tr>
<td>● A KCC/MC SOP on supporting the Mental Health and Community Trusts when an outbreak in the workplace or homes that they care for has been identified and control measures need to be implemented</td>
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<thead>
<tr>
<th><strong>Ambulance Services</strong></th>
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<tr>
<td>● A KCC/MC SOP on supporting the ambulance services when an outbreak among staff has been identified and control measures need to be implemented</td>
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<thead>
<tr>
<th><strong>Local outbreak triggers &amp; process:</strong></th>
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<tbody>
<tr>
<td>● If multiple cases of COVID-19 (suspected or confirmed) are linked to exposure within a care setting, PHE will consider the severity and spread of the outbreak, current control measures, the wider context and will jointly consider with the NHS and LA the need for an OCT.</td>
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<tr>
<th><strong>Resource capabilities and capacity implications:</strong></th>
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<tbody>
<tr>
<td>● Vehicles with aerosol generating procedures need to follow a thorough decontamination procedure. An appropriate auditing procedure should be in place to ensure decontamination is being conducted accurately in ambulances.</td>
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<thead>
<tr>
<th><strong>Links to additional information:</strong></th>
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<tbody>
<tr>
<td>● <a href="#">Primary Care COVID19 guidance</a></td>
</tr>
<tr>
<td>● <a href="#">SOP for GP surgery</a></td>
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<tr>
<td>● <a href="#">RCGP’s website.</a></td>
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<tr>
<td>● <a href="#">SOP for Community Pharmacy</a></td>
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<tr>
<td>● <a href="#">SOP for urgent dental care &amp; phased transition</a> for dental services</td>
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<tr>
<td>● <a href="#">SOP for community health services</a></td>
</tr>
<tr>
<td>● <a href="#">Legal guidance for mental health, learning disabilities and specialised commissioned mental health services</a></td>
</tr>
<tr>
<td>● <a href="#">Management of staff and exposed patients/residents in health and social care settings</a></td>
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Appendix 4 – Shelters, Refuges, Hostels & Other Temporary Accommodation

<table>
<thead>
<tr>
<th><strong>Including:</strong></th>
<th>Homeless shelters, domestic abuse refuges, caravan parks, hotels, and any other facilities providing temporary accommodation</th>
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<tbody>
<tr>
<td><strong>Objective:</strong></td>
<td>To closely monitor cases of COVID-19 amongst homeless, vulnerable populations, survivors of domestic abuse/their children and any others living in temporary accommodation, ensuring any outbreaks are managed quickly and efficiently.</td>
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</tbody>
</table>
| **Context:** | - The homeless shelters/accommodation sector include temporary accommodation hostels, B&B, housing association, local authority, private sector properties leased by LAs or Housing Associations and “other” types including private landlords.  
- The domestic abuse refuges in Kent and Medway are offered by Domestic Abuse Support Services which includes emergency safe accommodation, where survivors of domestic abuse and their children are housed. |
| **What’s already in place:** | - Hostels, shelters & other temporary accommodation settings should continue to follow guidance for hostels or day centres for people rough sleeping, for domestic abuse safe accommodation or advice for other accommodation providers in order to reduce risk. |
| **What else will need to be put in place:** | - As we start to prepare for recovery and transition those in temporary safe accommodations into longer term housing, there is a need for testing to be extended to those who are asymptomatic. There may be resistance on the part of landlords/ladies to house vulnerable populations without a negative COVID-19 test. An SOP must be developed by KCC and MC to inform housing managers of alternative solutions to finding appropriate accommodation for this population in case challenges are encountered.  
- An OCT may be required if a substantial outbreak occurs within an emergency accommodation setting. In this instance, great care must be taken when sharing sensitive health information with housing managers. |
| **Local outbreak triggers & process:** | - If one of the staff or residents in this setting has received a positive test result or if an outbreak is suspected, PHE HPT should be contacted immediately.  
- PHE HPT and KCC/MC will undertake a risk assessment and conduct a rapid investigation and advise on the most appropriate action to take. Depending on the risk assessment outcome, the PHE HPT and KCC/MC may establish an OCT to help manage the situation. The OCT will lead the Public Health response and investigations and put appropriate interventions in place. This may include;  
  - PPE and face coverings;  
  - Handwashing and respiratory hygiene or hand sanitisers  
  - Social distancing;  
  - Cleaning and waste management to maintain hygiene;  
  - Workforce management; |
In the case of cramped temporary housing accommodation which does not have space for social distancing and hand washing facilities may be shared, other measures may have to be taken as specified by the OCT

**Resource capabilities and capacity implications:**

**Links to additional information:**
- [Working safely during coronavirus](#)
- [COVID-19: guidance for domestic abuse safe accommodation provision](#)
- [COVID-19: cleaning in non-healthcare settings](#)
- [NHS test and trace: workplace guidance](#)
- [COVID-19 Advice for Accommodation Providers](#)
- [Staying alert and safe (social distancing)](#)
- [COVID-19: guidance for hostel or day centre providers of services for people experiencing rough sleeping](#)
### Appendix 5 – Prisons & Detention Facilities

**Including:** Custody services & prison escorts, detention/immigration removal centres, approved premises

**Objective:** To reduce the risk of transmission and eliminate new cases and deaths from COVID-19 in prisons and places of detention in Kent and Medway.

**Context:**
- There are 8 prisons in Kent and Medway – 4178 prisoners
- There are no detention/immigration centre in Kent and Medway
- There are 100 Approved Premises in Kent and Medway – 89 staffed and run by the National Probation Service (part of Her Majesty’s Prison and Probation Service) & 11 staffed and run by private providers under contract to Her Majesty’s Prison and Probation Service
- Ten of the 100 Approved Premises also work in partnership with a specialist NHS mental health provider.
- Capacity across Approved Premises in Kent and Medway is over 2,000 places with staffing includes probation staff, contracted cleaners, chefs and facilities management staff & third sector organisations delivering interventions and resettlement services

**What’s already in place:**
- Testing for residents is coordinated via Pillar 1 testing via PHE’s HPT.
- All prisons have a dedicated COVID contact tracing lead.
- Her Majesty’s Prison and Probation Service and PHE have also worked together to produce detailed operational guidance for the prevention, identification, escalation and management of outbreaks in custodial settings, including compartmentalization/cohorting arrangements.
- An Exceptional Delivery Model was put in place for all Approved Premises, which includes the following features;
  - The temporary closure of a small number of Approved Premises to ensure operations could be maintained.
  - The suspension or modifying of activities incompatible with social distancing.
  - All rooms became single occupancy. This was achieved through expediting move on plans for residents where the risk they presented to the public was sufficiently low, and the introduction of a priority referral process which ensured the remaining capacity was appropriately targeted.

**What else will need to be put in place:**
- Routine testing of all staff will need to be instituted
- New prisoners will need to be tested prior to being incarcerated in a facility.

**Local outbreak triggers & process:**
- If a COVID-19 outbreak is suspected in a prison or detention facility, the PHE HPT and KCC/MC will undertake a risk assessment and conduct a rapid investigation and advise on the most appropriate action to take. Depending on the risk assessment outcome, the PHE HPT and KCC/MC may establish an OCT to help manage the situation.
- All detainees with suspected or confirmed COVID-19 transported and managed according to the transportation and transfer guidance.
- Any staff member showing symptoms should be sent home immediately and they must follow Government guidance.
**Resource capabilities and capacity implications:**
- Prison officers to enforce control measures and escort and transport detainees who need to be transferred
- Healthcare staff to test both detainees and prison staff

**Links to additional information:**
- COVID-19: prisons and other prescribed places of detention guidance
- Working safely during coronavirus
- COVID-19: prisons and other prescribed places of detention guidance
- Coronavirus (COVID-19): courts and tribunals planning and preparation
- Courts and tribunals tracker list during coronavirus outbreak
- HMCTS weekly operational summary on courts and tribunals during coronavirus (COVID-19) outbreak
- Cleaning in non-healthcare settings
- Coronavirus (COVID-19) and prisons
- COVID-19 getting tested
- National contingency plan for outbreaks in prisons and other places of detention
- Approved Premises
Appendix 6 – Other Workplace Settings

**Including:** Construction site/outdoor working, manufacturing, food delivery, takeaways & mobile catering, in-home workers (e.g. plumbers, cleaners and in-home beauticians etc.), retails/shops, factories, power plants, food processing plants, armed forces & courts, leisure centres, sports clubs, gyms, pools, salons, and faith/religions settings.

**Objective:** To identify and eliminate all cases of COVID-19 in workplaces to protect employees, visitors and customers during the gradual restarting of the local economy and movement of the population.

**Context:**
- There are various types of construction and outdoor work settings in Kent and Medway. They include a significant number of waste management facilities/services of medium size (10-500 employees) and several water and wastewater treatment sites, laboratories, power plants and call centres;
- Kent and Medway have 2,490 food and drink production enterprises as of 2019.
- Kent and Medway have 71,435 manufacturing businesses as at 2019.
- Food delivery has played an important role in the consumer sector in Kent and Medway delivering food and edible items to home environments.
- The Armed Forces community in Kent and Medway includes Army, Royal Navy and Royal Air Force (RAF);
  - Army - 11th Infantry Brigade (South East); Royal Regiment of Artillery; (3rd Battalion PWRR; 103 REME battalion; 254 Medical Regiment & 220 Medical Squadron; 1 RSME Regiment, 259 Field Squadron & 101 Engineering Regiment; 39 Engineering Regiment (Hybrid)
  - Royal Navy - Royal Navy (Medway) Reserve & The Royal Marines Reserve Unit in London
  - RAF - 360 reserves; 6360 cadets & cadet volunteers; 29 Cadet Force Units
- In addition, in Kent and Medway,
  - There are 4 county & family courts
  - There are 12 leisure centres, many independent gyms and sports clubs.

**What’s already in place:**
The NHS T&T service supplements risk mitigation measures taken by employers by identifying people who have had close recent contact with someone who has tested positive for COVID-19 and advising them to self-isolate, however, it does not change the existing guidance about working from home wherever possible. Employers should continue to follow the guidelines to prevent the spread of COVID-19 to reduce risk. In the event of an outbreak, employers should immediately inform the PHE HPT. Employers must;
- Carry out a COVID-19 risk assessment following the Health and Safety Executive guidance;
- Develop cleaning, handwashing and hygiene procedures in the workplace;
- Help employees to work from home; discuss home working arrangements and ensure they have the right equipment for remote working;
- Maintain 2m social distancing, where possible; put up signs to remind workers and visitors of social distancing guidance and use tape to mark 2m distance between workspaces where appropriate;
- Where people cannot be 2m apart, manage transmission risk by using screens or barriers to
separate people from each other and staggering arrival and departure times;

- When necessary, consider methods to reduce frequency of deliveries
- A number of practical safety measures including new signs, street markings and temporary barriers to ensure Kent and Medway’s high streets are ready for when businesses are able to open and trade safely.

The communications team at KCC is working with different departments within KCC and Kent DCs (trading standards, community wardens, town planning, environmental health), other public sector teams (police enforcement officers) and private sector organisations (e.g. federation for small businesses) who already have direct links with businesses. They will work together to ensure businesses in Kent are supported and that they are adhering to infection control guidance. Government advice on what financial support is available for businesses during COVID-19 is available here.

A number of businesses and organisations are also required by law to have a system in place to collect the contact details of their customers. KCC & MC as supporting businesses to incorporate the NHS T&T App and QR code as part of this requirement.

While national lockdown is in place, it is more important than ever to continually refer to government guidelines on how to work safely. This can be accessed here.

PHE’s Consumer Workplace Action Cards provide significant detail on outbreak management in the workplace and when it is appropriate to contact the HPT for their involvement.

What else will need to be put in place:

- A KCC/MC SOP on supporting the business sector when an outbreak in the workplace has been identified and control measures need to be implemented

Local outbreak triggers & process:

- If a COVID-19 outbreak is suspected in a workplace setting, the workplace will inform PHE HPT and KCC/MC will undertake a risk assessment and conduct a rapid investigation and advise on the most appropriate action to take. Depending on the risk assessment outcome and the scale of the outbreak, the PHE HPT and KCC/MC may establish an OCT to help manage the situation. The OCT will lead the Public Health response and investigations and put appropriate interventions in place.
- Symptomatic individuals should access testing in line with current advice. Advice and information provided through contact tracing should be followed by all symptomatic individuals and their contacts.

Resource capabilities and capacity implications:

- Staffing to;
  - Develop communications plan and SOPs,
  - Monitor workplaces as part of prevention work;
  - Visit non-compliant workplaces to enforce control measures;
  - Visit workplaces with outbreaks to advise on/enforce control measures;

Links to additional information:

- NHS test and trace: workplace guidance
- Working safely during coronavirus
● Guidance on prioritising waste collection services during coronavirus (COVID-19) pandemic
● Guidance for Managing Household Waste and Recycling Centres (HWRCs) in England during the coronavirus (COVID-19) pandemic
● Information on the water industry and Coronavirus (COVID-19)
● Guidance for food businesses during COVID-19
● Cleaning in a non-healthcare setting
● Managing a funeral during the coronavirus pandemic
● Need FSA guidance for food businesses on COVID-19
● Guidance for restaurants offering takeaway or delivery
● Food Handlers - Fitness to work
● Guidance for working in, visiting or delivering to other people’s homes
● COVID-19: investigation and initial clinical management of possible cases
● Find your local Health Protection Team in England
Appendix 7 – Transport Arriving via Trains, Ports & Borders

Including: All transport that has arrived in Kent and Medway that originated outside the UK (except those listed in Appendix 8). This includes freight/lorry drivers, cruise ships and trains

Objective: To prevent and control the spread of imported cases of COVID-19 from overseas travellers entering into the UK

Context:
In Kent and Medway there are 4 ports and a harbour.
- Port of Whitstable: fishing, small commercial
- Port of Ramsgate: fishing, leisure, lifeboat
- Port of Dover: ferry, leisure, commercial/cargo, cruise terminals, lifeboat
- Folkestone: difficult, largely derelict

In Medway, the ports include Chatham Docks, Chatham Reach and Upnor Reach

There is a high-speed international train service from Paris, France, that goes via Ebbsfleet International and Ashford International and ends at London St. Pancras International

Buses and cars arriving in Folkestone from France via the Eurotunnel

What’s already in place:
- UK travel quarantine rules have come into effect requiring all people arriving in the UK to self-isolate for 14 days. People arriving by plane, ferry or train – including UK nationals – will have to provide an address where they will self-isolate and face fines of up to £1,000 if they breach the rules.
- Checkpoints have been set up on roads in line with KCC Brexit preparedness plans
- During the national lockdown (initially running November 5th to December 2nd) an array of businesses will have to temporarily close or change operations. Information on these changes can be found in great detail here.
- The government recently released guidance for the owners and operators of beach, countryside and coastal destinations to meet the challenges associated with both increased numbers of visitors (during periods of eased restrictions) and decreased numbers of visitors (during periods of tightened restrictions). This can be accessed here.

What else will need to be put in place:
- Provision of support for food and medical supplies for the 14 days self-isolation period in the event of an outbreak on a cruise ship
- Driver welfare provisions

Local outbreak triggers & process:
- For UK residents, self-isolating in a normal place of residence is unlikely to result in outbreaks.
- For visitors, self-isolation in commercial accommodation such as hotels etc has the potential to result in outbreaks in commercial premises. PHE’s HPT will conduct a risk assessment to provide advice and guidance on how to respond in such a situation and, in exceptional circumstances, hold an OCT.

Resource capabilities and capacity implications:
- Provision of support for food and medical supplies during the 14 days self-isolation period

**Links to additional information:**
- [COVID-19: Shipping and seaports guidance](#)
- [Arrangements for driver welfare and hours of work during the coronavirus outbreak](#)
- [Border control](#)
# Appendix 8 – Other Transport

<table>
<thead>
<tr>
<th><strong>Including:</strong> Bus, Taxi, Walking &amp; Cycling, Private cars, Car sharing</th>
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<tbody>
<tr>
<td><strong>Objective:</strong> To identify and eliminate all cases of COVID-19 in any other method of transport to protect employees, visitors and customers during the gradual restarting of the local economy and movement of the population.</td>
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</tbody>
</table>

## Context:
In Kent and Medway, there are:
- 199 private car hire companies
- 18 coach service operators

## What’s already in place:
- It is currently compulsory to wear a face covering on all public transport including private hire cars.
- Car sharing or public transport should be discouraged as possible.

## What else will need to be put in place:
- A mobile app or similar, to contact trace all public transport contacts

## Local outbreak triggers & process:
- Public transport associated with an area where there is a localised community outbreak will need to be considered by the OCT
- However, this can only become a reality when the mobile phone app is in place nationally, the majority of the public use it, and the government decides how to respond to increased incidence of COVID-19 associated with a particular transport route/hub.

## Resource capabilities and capacity implications:

## Links to additional information:
- [Coronavirus (COVID-19): safer travel guidance for passengers](#)
- [Bus Operator Directory](#)
- [Private car hire Directory](#)
# Appendix 9 – Outdoor Settings

**Including:** Parks and green spaces, outdoor gyms, entertainment resorts, tourist attractions, beaches, playgrounds, pools, funeral grounds, zoos

**Objective:** To ensure compliance to social distancing measures to manage transmission risks and deaths from COVID-19 in outdoor community settings in Kent and Medway

**Context:** Public parks and green spaces. Green spaces will typically include parks, recreation grounds, publicly accessible playing fields, public open spaces associated with housing developments and public burial grounds. These areas are likely to be enclosed by a variety of boundaries with ‘pinch points’ at entrances.

**What’s already in place:**
- In England, Kent and Medway residents can leave their home to exercise and spend time outdoors for recreation, sports and other activities with their household or support bubble or in groups of up to 6 people from another household or support bubble.
- Currently overnight stay is not allowed (with some exceptions) with campsites and caravan parks closed.
- All staff should wear face masks if social distancing is not feasible.
- PHE released a guidance for providers of outdoor facilities on the phased return of sport and recreation in England.
- Outdoor Rule-of-6 guidance applies to any outdoor activity, unless it is a “licensed physical activity” or a sport and should take account of the need to ensure the safety of any participants in line with current relevant COVID-19 regulations.

**What else will need to be put in place:**

**Local outbreak triggers & process:**
- Symptomatic individuals should access testing in line with current advice. Advice and information provided through contact tracing should be followed by all symptomatic individuals and their contacts.

**Resource capabilities and capacity implications:**
- Staffing to monitor compliance and impose social distancing measures in outdoor community settings

**Links to additional information:**
- [Working safely during coronavirus](#)
- [Coronavirus (COVID-19): safer public places - urban centres and green spaces](#)
- [Coronavirus – guidance on accessing green spaces safely](#)
- [Cleaning in non-healthcare settings](#)
- [NHS test and trace: workplace guidance](#)
- [Guidance for people who work in or run outdoor working environments](#)