Wiltshire Local Outbreak Management Plan

The Local Outbreak Management Plan (LOMP) is a framework document outlining the role of the Local Authority in the management of the COVID-19 outbreaks in Wiltshire. The framework provides a consistent set of principles and approaches by which Wiltshire will manage what is a very dynamic situation. Underneath this framework there will be a set of detailed plans that will also change and evolve.

The LOMP will allow improved speed of response, thorough planning and deployment of resources, building on local expertise led by the Chief Executive Officer and Director of Public Health working with the regional PHE health protection team.

The principles to our approach are as follows:

- We will build on existing health protection processes, not duplicate them
- We will ensure testing takes place quickly and tracing contacts of those who have tested positive occurs at pace, advising them to self-isolate
- We will aim to keep the virus under control through improved co-ordination whilst maintain community engagement
- The governance arrangements associated with our LOMP will provide the structure and responsibility to enable a place-based approach
- Our assurance role will ensure we build on local knowledge and real time data flow between local and national systems
- We will ensure that robust evidence and local knowledge steer a consistent approach to our decision making
- We will work with neighbouring Local Authorities and key partners such as health and the LRF as required to ensure consistency of decision-making and public messaging.

Nationally, seven themes have been identified as being essential to an effective outbreak management plan. These are detailed below and are woven throughout our plan:

1. Care homes and schools
2. Identify high risk settings, communities, places (for example, schools, care homes and factories)
3. Local testing capacity
4. Contact tracing
5. Data integration
6. Vulnerable people
7. Governance

1. **Introduction**
    - National context
    - Aim and Principles
    - Working in partnership
        - LRF
        - STP/Health System
        - Neighbouring authorities
        - Town and Parish Councils
        - Voluntary sector / communities
        - Other

2. **Governance**
    - **Covid-19 Health Protection Board**

    (Addresses Theme 7)
    - **Local Outbreak Engagement Board**

    (Addresses Theme 7)
        - Leadership
        - Communication
        - Engagement

3. **Data Integration**

    (Addresses Theme 5)
    - Consistent method to be agreed across SW
    - PHE / LAs/ NHS
    - Note to include Joint Biosecurity Centre

4. **Prevention and Response Plans for Places and Communities**

    (Addresses themes 1 and 2)
    - Care homes
    - Schools
    - High risk places, locations and communities)

5. **Protecting and supporting vulnerable people**

    (Addresses theme 6)

6. **Testing and contract tracing: responding to outbreak in complex settings**

    (Addresses Themes 3 and 4)
    - NHS Test and Trace Service

    Testing
    - Pillar 1
    - Pillar 2
    - Mobile LRF
    - Agile deployment for outbreak

    Contact Tracing
    - Tier 2 – 3
    - Tier 1 - refer MOU

7. **Communication & Engagement**

8. Resources

- LA & PH capacity and arrangements including surge arrangements (including managing expectations).
- PHE capacity and function

1. Introduction

a. Global Context

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China. On 12 January 2020 it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19.

As of 10 June 2020, over 7.2 million cases have been diagnosed globally, with more than 411,000 fatalities. (European Centre for Disease Prevention and Control, situation update worldwide). The WHO coronavirus dashboard has country by country information. WHO also publishes a daily international situation report

b. National Context

The total number of confirmed cases in the UK is published by the Department of Health and Social Care, and is available in a visual dashboard. As of 10 June 2020, there have been 290,143 lab-confirmed UK cases and 41,128 Covid-19 associated UK deaths.

c. Local Context

Wiltshire, in common with most of the South West, has been relatively lightly affected so far, with case and death rates under half the national average. This low impact means that most of the population will not have been infected and therefore not have gained whatever immunity that might afford.

Therefore, it remains vital that we maintain full attention to minimising the risk of viral transmission into the future, whether at home, work, school, or in our communities. This outbreak management plan will put a system in place to identify and suppress possible outbreaks before they can gain momentum. This is the system of testing, tracing and self-isolating that is currently being set up.

The Council will encourage and support residents and local institutions of all types to operate safely. And, as the local base of public health, environmental health and adult care teams we have a key role in working alongside national and regional parts of the test and trace system to enable the whole to function at a Wiltshire level. We also have a further specialist role in preventing local outbreaks through advice and training in vulnerable settings, particularly care homes, but also schools and certain other institutions.

d. Aims, Purpose and Principals

Aim

The aim of the LOMP is to harness the capacity of the Council, working with a wide range of partners, to enable residents of Wiltshire to resume their normal lives as far as possible, while being protected from the threat still posed by COVID-19.

Overarching Purpose

Local Authorities have a significant role to play in the identification and management of COVID-19 outbreaks. Our plan will give clarity on how local government works with the NHS Test and Trace Service to ensure a whole system approach to managing

local outbreaks. Directors of Public Health have a crucial system leadership role to play ensuring that through the LOMP they have the necessary capacity and capability to quickly deploy resources to the most critical areas. Response to local outbreaks, while led by DsPH, need to be a co-ordinated effort working with PHE local health protection teams, local and national government, NHS, private and community/voluntary sector and the general public.

Core working principles for Wiltshire DPH agreed across SW region

1. We will work together as a public health system, building on and utilising the existing close working relationships we have between the local authority public health teams and PHE. We will endeavour to ensure we make best use of the capacity and capability of the regional public health workforce.

2. While recognising local sovereignty we will commit to ensuring a common language to describe the local governance arrangements:

a. COVID-19 Health Protection Board
b. Local Outbreak Management Plans (LOMP)
c. Local Outbreak Engagement Board

3. We will ensure that we all work to an agreed common set of quality standards and approaches in the management of local outbreaks, utilising and building upon already agreed approaches such as those defined within the Core Health Protection Functions MoU.

4. We will adopt a continuous learning approach to the planning and response to COVID-19 outbreaks, sharing and learning from one another to ensure we provide the most effective response we can.

5. We will ensure that there is an integrated data and surveillance system established, which alongside a robust evidence-base will enable us to respond effectively to outbreaks. Proposal that a COVID-19 Regional Data and Intelligence Framework is developed which will enable DsPH to have access to the necessary information to lead the COVID-19 Health Protection Board.

6. We will commit to openness and transparency, communicating the most up to date science, evidence and data to colleagues, wider partners and the public.

7. We will ensure that within our planning and response to COVID-19 we will plan and take the necessary actions to mitigate and reduce the impact of COVID-19 on those most vulnerable, including BAME communities.

8. We recognise that DsPH have a system leadership role in chairing the COVID-19 Local Health Protection Board. We commit to actively engaging with key partners, including all levels of government (Upper, lower tier local authorities, towns and parishes and wider partners and communities), key stakeholders including the community and voluntary sector to ensure a whole system approach.

9. We accept that we are currently working in a fast-changing, complex environment. DsPH are having to respond dynamically to changing evidence, national guidance, demands and expectations. We will commit to be actioned focused and commit to working to public health first principles.

10. We will ensure that our LOMP includes a strong focus on prevention and early intervention to ensure key settings (e.g. care homes and schools) and high-risk locations and communities identify and prioritise preventative measures to reduce the risk of outbreaks.

e. **Working in Partnership**

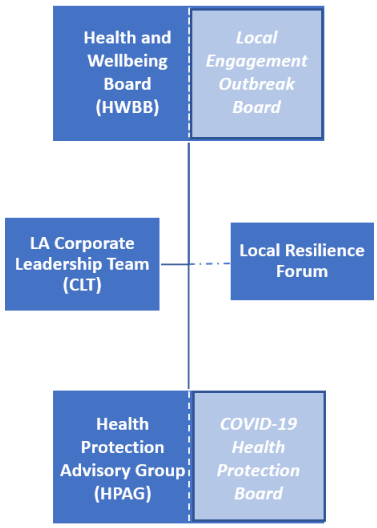
Wiltshire will work in partnership with PHE, CCG, JBS, LRF, Swindon Borough Council and other neighbouring local authorities to ensure a consistent and well informed regional response. Details of any outbreaks **on the** border to another local authority will be shared as a routine matter. (Full details of partnership roles and responsibilities are attached at Appendix 1)

2. Governance

a. The LOMP will be developed in conjunction with the newly established COVID-19 Health Protection Board, this will be a new arm of the Wiltshire Health Protection Assurance Group (HPAG). Its function will include managing information and coordinating and supporting local efforts to preventing and minimising outbreaks. This all links closely to the test and trace system. This board will be chaired by the director of public health, and in her absence a consultant in public health.

The HPAG will develop a COVID-19 function and business as usual function. The COVID-19 function will ensure membership from Executive Member for ASC and Public Health, CCG, and PHE. (Covid19 Health Protection Board TOR attached at Appendix 2)

The Health Protection Assurance Group (HPAG) will report to Wiltshire's Health and Wellbeing Board (H&WBB) and LA Corporate Leadership Team (CLT) as well as wider reporting to the LRF.



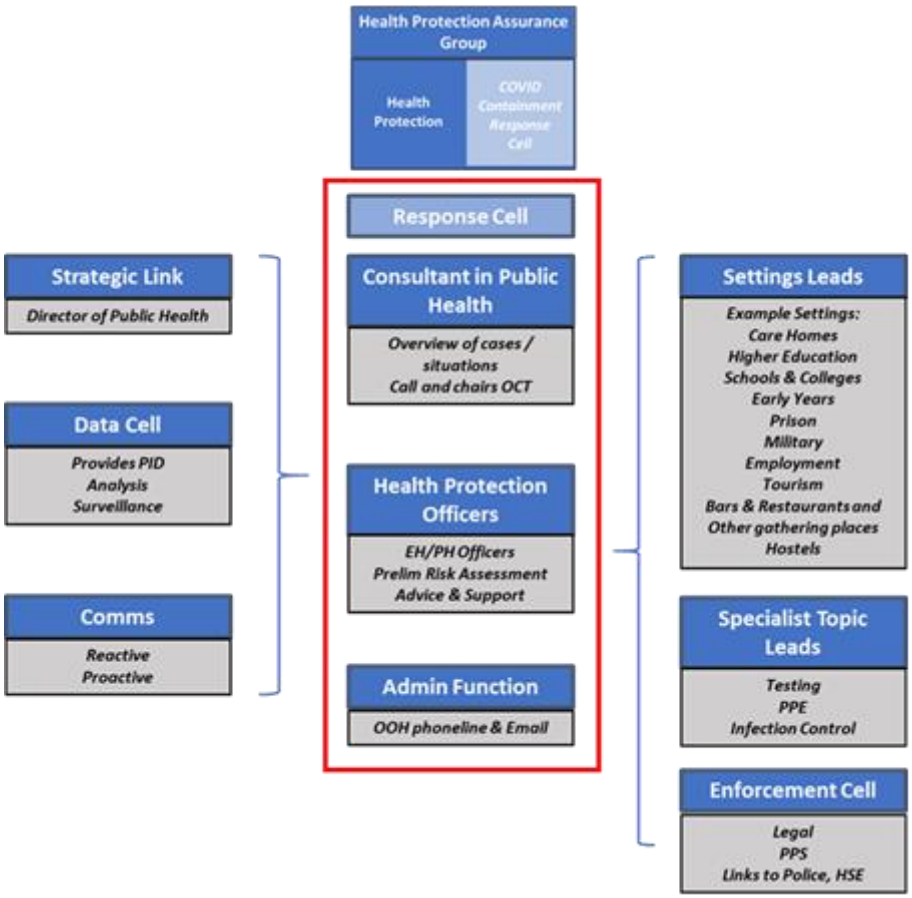
A Wiltshire Outbreak Engagement Board, chaired by the Council Leader will play a critical role in ensuring that local residents and other stakeholders in the public, private and third sectors all understand and abide by the need to comply with rules and principles designed to prevent viral transmission. The main focus of this board will be outwards to the community. (Local Outbreak Engagement Board TOR attached at appendix) We will develop the Health & Wellbeing Board (HWBB) remit to enable it to drive the Member-led engagement board. This will ensure a place-based approach is taken via engagement with key stakeholders already present on the HWBB. The current strategy can be found at the following link:

http://www.wiltshire.gov.uk/adult-care-joint-health-and-wellbeing-strategy

b. Wiltshire COVID-19 Containment Response Cell

The Wiltshire COVID-19 containment response cell processes the information provided to it from either the wider system and/or direct contacts from individuals or organisations locally on a daily basis. It assesses the risk and works under the protocols from PHE. Clinical issues around public health will be resolved via PHE CCDCs, other clinical issues through patients GP and/or CCG clinical leads.

The cell will operate in full for 5 days per week initially, with skeleton support over the weekends and evenings, with a rolling assessment of the need to operate longer hours. 24/7/365 may be required.



The core part of the response cell will comprise of admin support, environmental health or public health officers, and the oversight of a public health consultant. Their role is to carry out initial and dynamic risk assessment, link in to topic and settings expertise (agreeing the best person to take the lead role for the named incident), review progress, and set up and chair Outbreak Control Teams (OCTs) as and when required. They will include additional support as and when required, set up monitoring arrangements and close the incident when appropriate to do so.

The size of the officer and admin support will vary based on the number of incidents being managed.

Data and Intelligence

The Data cell will include:

- The receipt and handing of PID from PHE and other areas
- The analysis of local, regional and national data linking in with PHE
- Field epidemiology for specific incidents (e.g. compiling social networks and timelines to test hypotheses for spread of infection)
- Contribute to research and intelligence to support the development of approaches

Communications

Communications will have two main parts, proactive and reactive:

- Reactive; handling messages relating to outbreaks and incidents, ensuring that the need for open and honest communication is balanced with sensitivity around patient and business identifiable information
- Proactive; considering the importance of behaviour change around COVID-19, with a particular focus around two messages; staying at home if you or a household member have symptoms and getting a test.

Setting Leads

The setting leads are people who have strong links into specific settings and so can manage aspects of the incident. This might vary from acting in the HP Officer role to providing support to comms cell and the HP response on the stakeholder communication (for example, a particular type of business such as a B&B). Below is a list of suggested setting areas:

- *Care homes*
- *NHS/CCG*
- *Higher Education*
- *Schools and Colleges*
- *Early Years*
- *Prisons*
- *Military*
- *Employment*
- *Tourism*
- *Restaurants & Bars and other gathering places*
- *Shared Accomodation e.g Homeless hostels, HMO's, Refuges*
- *Food Factories*
- *Public gatherings and events*
- *Places of worship*
- *Emergency Services*

Specialist Topic Leads

This includes people who have specialist knowledge around specific topics, for example, PPE or testing. Often these will be the same people who are in the response cell. Current suggestions are;

- *Testing*
- *PPE*
- *Health & Safety*
- *Infection Control*

Enforcement

Enforcement may be required under certain circumstances. This may be through Public Protection Services (PPS), the Police,) or possibly PHE who are proper officer for Part 2a type orders regarding COVID, which allow for people to be detained to prevent spread. Or through other appropriate legislation pertinent to the setting. An example may be the Health and Safety At Work Act. However, we are still waiting for details about powers (particularly around local lockdowns) from Central Government and in the settings action cards details of relevant legislation will be detailed. This is

where we can draw on the other available legislative powers. (Further information is detailed in Appendix 4)

3. Data Integration

We will seek to pull together all the information relevant to individual cases and outbreaks with Wiltshire Council, NHS partners and Public Health England while complying with General Data Protection Regulations (GDPR). This involves proactive data sharing and flows for contact tracing, outbreak management and ongoing surveillance will be key. We will expect relevant and appropriate data sharing from national and regional components of the system and highlight where any gaps are limiting our ability to act in an integrated fashion. Our approach to data sharing will be consistent across the Southwest region. This will also link with the central government through the Joint Biosecurity Centre.

The key principles to guide our approach to data integration are:

a. **Whole systems approach** – Wiltshire Council will take a whole systems approach, working with national, regional and local partners, recognising that no player has the resources, skills or expertise to make this happen on their own.

b. **Integration** – Wiltshire Council will work with partners to ensure that the local pathways, systems and data sharing are proactively integrated.

c. **Data sharing** – proactive data sharing and flows for contact tracing; outbreak management and ongoing surveillance will be key. We will expect relevant and appropriate data sharing from national and regional components of the system and highlight where any gaps are limiting our ability to act in an integrated fashion

d. **Responsiveness** – Wiltshire Council will be responsive to the differences and diversity in local communities, taking a people-centred approach to understanding how we can support people, communities, business and organisations to suppress outbreaks.

e. **Capacity and resources** – these must be provided across all levels to ensure the programme is run effectively and sustainably, and a key component will be the ability of the national programme to deliver on contact tracing and the provision of advice. Partners across the county will be asked to support the outbreak response wherever possible, however it must be recognised that if there are increasing cases the capacity to respond may be overwhelmed. Capacity gaps will to be reported through the governance system on a weekly basis.

f. **Ownership** – Wiltshire's COVID-19 LOMP is jointly owned by Wiltshire Council's Health Protection Board under the leadership of the DPH, in line with government guidance on health protection and the role of the DPH

We will review local, regional and nationally available data and enable parity of esteem between NHS and LAs, our aim being to regularly review our local situation against the national COVID-19 alert system.

4. Prevention and Response Plans for Places and Communities

Prevention and response plans for Wiltshire Council are based on the Local Health Resilience Partnership's Communicable diseases plan. In addition, the joint biosecurity centre will be looking for trends in settings to provide prevention interventions.

Triggers

- Surveillance Data
- Evidence from Partners

Prevention

- Social distancing
- Hygiene
- Testing, Tracing Isolating
- Appropriate use of personal protective equipment

Risk

- Identification and plans for at risk groups / individuals
- Individual Organisations Risk Assessment as part of business plans

Response

- Identification and management of an outbreak
- ICT - Testing and tracing
- Closure / containment
- Other arrangements
- Communication

Sector	**Focus**	**Theme leads**	**Partners**
Care Homes	Care Home cell	Helen Jones	Care Home Cell CCG GWH community services
Schools	Education Cell	Helean Hughes	School Leaders Parents
Colleges	As in schools	As in Schools	Trowbridge, Chippenham & Salisbury College Lackham College
Children and YP	FACT / Safeguarding Recovery	Lucy Townsend	
High risk settings and prisons	Prison	PHE and Prisons	Health and Justice PHE/ NHSEI NPS AWP – Healthcare provider @ Erlestoke
Vulnerable Individuals and groups	Vulnerable persons cell Examples include Refugees and Asylum seekers, Gypsy, Traveller and Roma and boaters, Homelessness, Disabled people and carers, People with LD and autism	Nicole Smith – lead for Gypsy & Travellers and Homelessness Claire Edgar - - Learning disabilities and autism	
Businesses and Employers	Factories	John Carter – Public Protection	

		Sam Fox – Economic Development	
Military			
Tourism		Sam Fox – Economic Development	
Hospitals and Hospices			
Places of Worship			
Public gatherings – licenced events		Linda Holland - Licensing	

5. Protecting and supporting vulnerable people

a. Vulnerable people are those who may be more at risk of catching Covid-19 or having a worse outcome if they do get it. This may be due to:
- an internal vulnerability (e.g. pre-existing mental or physical health condition)
- the environment in which people live or work (e.g. rough sleeping)
- an addiction or health behaviour (e.g. drug or alcohol use)
- ability to understand advice or act on it (e.g. people with a learning disability, dementia or language barriers).

b. There is also a cohort of people who are vulnerable to worse outcomes for Covid-19 due to demographic or occupational reasons[1] although this research did not take into account co-morbidities:
- age (among people already diagnosed with COVID-19, people who were 80 or older were seventy times more likely to die than those under 40)
- gender (men were more likely to die from COVID-19 than women)
- deprivation (living in a more deprived areas)
- ethnicity (higher risk of dying in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups)
- occupation (those in caring occupations, those who drive passengers in road vehicles for a living, those in security related roles)

c. At a local level we will focus on protecting and supporting vulnerable people in a number of ways:

- Through identification and understanding of who is most vulnerable and where they are in the county using the information above. This will build on local knowledge through our JSNA work as well as with partners such as the voluntary and community sector and through existing groups and partnership working to ensure that people can be accessed quickly, and any response is appropriate to need

1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/890258/disparities_review.pdf

- Through partnership working to build on prevention and understanding people's concerns. We can work with key organisations and existing mechanisms such as our support calls to those who are shielding to ensure that the key prevention messages of social distancing, hand hygiene and test and trace are reaching everyone. We are planning a resident's survey at regular time points which can be used to identify influences on behaviour and variation between groups.

- Through ongoing support for those people who need to self-isolate via linking to processes with food and prescription delivery, and access to NHS and community support. This will build on the successful process in place for supporting people on the shielding lists to date and our collaborative working with the voluntary and community sector.

d. Through proactive raising awareness of the potential for outbreaks within different groups and ensuring a clear understanding of the need for and purpose of testing and contact tracing including:

- Access to translation services
- Recognition of the impact of hearing loss, sight loss and cognitive impairment and ensuring resources and communication are appropriate
- Identification of key leads who have up to date information for liaising with different communities

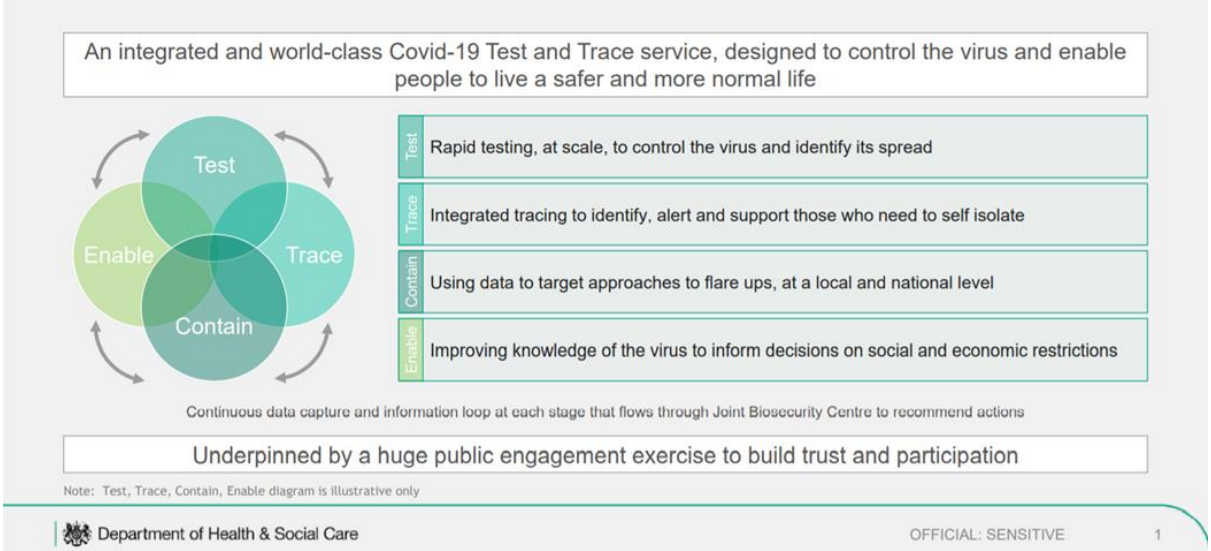
Wiltshire Specific Risk

Although Wiltshire does not have a port or university, the county does have some characteristics that should be considered in this context:

- Although we perform well on many health indices we do have pockets of deprivation across the county. However, these communities are often longstanding, and we have proactive community-based work in many of them
- Wiltshire is home to a prison.

6. Testing and contract tracing: responding to outbreak in complex settings

An integrated Covid-19 Test and Trace programme designed to control the virus and enable people to live a safer and more normal life was introduced across England on 28 May. Local Authorities will work with the Government to support test and trace services in their local communities, taking a place-based approach to containing the spread of the infection.



Testing and Tracing (TAT) is the central system to be used within the Test and Trace service. The phased approach of national roll-out begun on 01 June. The service comprises of three tiers:

- Tier 1 - Regional level enhanced PHE health protection team capacity, supported by local authorities as needed. This function will include roles such as convening local outbreak control team meetings and will focus on complex settings and outbreaks.

- Tier 2 is comprised of 3000+ health care professionals employed nationally to assess risk and provide support in more complex situations such as outbreaks in community settings;

- Tier 3 provides initial contact and advice to those testing positive and their contacts. This element is comprised of 15,000 call handlers.

a. Testing

In Wiltshire we have a locally based regional testing centre based in Salisbury and residents of Wiltshire living in the north of the county can access testing in Swindon. The sites have the capacity to test up to 2000 people a day. This is part of the national online portal offer with people receiving results within 72 hours. Health and social care staff and patients are able to access both symptomatic and asymptomatic testing via the digital portal. For all care homes, managers can order testing kits. Test results will be emailed to the registered manager, or directly to staff, within 72 hours of the test arriving at the laboratory.

In the case of positive test results, this triggers contact tracing as explained below.

The Local Health Protection team would be notified if there are two or more probable cases connected in time to a specific place (not a household), or an area or cohort of people with a significantly higher than expected rate of infection. This information will then be shared with the local authority.

As well as the regional testing centre described above there are mobile units across the south west. These have the potential to be deployed in the case of an outbreak.

The main point of contact for testing is the Director of Public health. Care home testing is overseen by a multi-agency Care Home Cell chaired by the BSW CCG.

Contact Tracing

For Confirmed Cases, following a positive test result, the National Contact Tracers at Tier 3 will speak to the case (case will have provided details to receive a test, either through the App or via the other mechanisms (website or phone number for individuals, care home portal for care home residents and staff, key workers through management system or web/phone portal). They will be advised to self-isolate until 7 days (or longer if required).

Tier 3 will identify their contacts and record them. They will follow up on individual named contacts. If this flags any key issues, for example vulnerability or complexity these will be referred through to Tier 2 for further investigation.

Tier 3 (and Tier 2 if the case has been passed to Tier 2) will identify any contexts such as workplaces, schools or other contexts that they have spent enough time to have potentially been in contact with others (this might include social or leisure, shopping, healthcare visits etc). These contexts will be passed through to Tier 1.

We would expect that the databases from the NCTS would be searching for contexts (PHE software, HP Zone, automatically detects possible outbreaks by searching for the same place in different case histories). Local authority public health teams can add local insight and knowledge as appropriate and work closely with Public Health England and the tier 1 team.

If an outbreak is declared, then the local authority and PHE roles would liaise as outlined in the SW HP MOU.

Outbreak recognition and declaration

The definition of an outbreak could be interpreted in this context to mean:

- Two or more cases connected in time to a specific place (not a household)
- An area or cohort of people with a significantly higher than expected rate of infection (this would be compared to other similar areas at that time)

The first definition would likely be the focus for the containment plan, however an important factor would be the analysis and interpretation of patterns across the county. Patterns amongst people, layered with information about their movements, might enable us to identify places where people might not consider themselves to have spent significant time but are important in the transmission chain.

The initial notification of an outbreak would reach the response cell, who would carry out:

- Initial investigation of the incident to understand the nature of the outbreak
- Risk assessment undertaken and recorded to include:
    - Likely size of exposed cohort
    - Vulnerability of the people impacted (medical)
    - Current infection control measures in place
    - Barriers to self-isolation / control measures (social, circumstantial)

- Information assessed by the lead PH Consultant (which could be within the LA or PHE)
- Either outbreak declared in which case an Outbreak Control Team is set up, or a timeline for review is set.

If the risk assessment suggests more intensive intervention is required, the following steps would occur:

Outbreak investigation and containment

Appropriate format for the outbreak control team to be instigated. These will vary based on the setting; where there is already a team liaising with the specific stakeholders or with expertise, they will lead on the initial response.

Protocols will be developed for responding to different types of outbreaks (these will use current guidance and frameworks from PHE). A typical response is likely to involve:

- additional case finding and contact finding
- infection control information and advice for the setting/context
- this may involve closure, cleaning and reopening
- this may involve advice for future operations, if any improvements are identified
- identification of any barriers to compliance to the setting or individuals concerned, with a view to reducing them
- follow up to ensure measures put in place have been successful
- dissemination of any lessons learnt to wider relevant settings/contexts (with due attention to patient confidentiality issues)
- communication will be important throughout to a range of stakeholders including communities

Data collection flows and information analysis

Data will likely be collected through a variety of sources, but key will be:

- NCTS
- Testing – clinical systems reporting positive results
- NHSX COVID-19 App

Currently there is little data flow of patient identifiable information between NHS/PHE and LA – this will be required to make this successful.

Data analysis will be carried out at multiple levels, and there will be a requirement for a local epidemiology/intelligence cell to be convened which links LA, NHS and PHE to ensure we maximise the use of the resources to provide actionable information.

This will include identification of significant variation in cases or contact numbers, and forecasting.

Local intelligence will be applied for example in identification of settings or contexts of interest.

7. Communication and Engagement

Communications will have two main parts, proactive and reactive.

- Reactive; handling messages relating to outbreaks and incidents, ensuring that the need for open and honest communication is balanced with sensitivity around patient and business identifiable information

- Proactive; considering the importance of behaviour change around COVID-19, with a particular focus around two messages; staying at home if you or a household member have symptoms and getting a test.

The DPH will work with locally elected members to brief regarding the progress of contact tracing and issues (e.g. non-compliance / public comms) to ensure greater impact. They will also have a responsibility to our general population to provide a local communication route that people trust and use that will allow them to:

a. understand the need for the contact tracing and how data about contacts will be used and to stop the vigilante movement taking a grip locally;

b. respond to notifications that they have been a contact, that will allay fears, provide appropriate responses regarding isolation and testing and ensure that people will seek medical support at the right time.

There is also a need to ensure that the local voice is heard through active engagement with local communities. Wiltshire will establish a Local Engagement Stakeholder Board (Health & Wellbeing Board) which will provide this voice both directly and via liaison with other community groups, Parish council and interested stakeholders.

The PHE regional team will work with DsPH and local system leaders to brief regarding the national and regional progress of contact tracing and support with ensuring consistent public messaging through agreed 'shared' proactive and reactive lines with common issues (e.g. reports of non-compliance with isolation / use of COVID 19 ACT).

8. Resources

Typically, a busy but manageable scenario would be to have capacity to support outbreaks in a modest number of settings, working with PHE, for example 10 care homes, one prison, 5 schools (i.e. a low percentage of outbreaks in settings).

In this busy but manageable scenario, the resources deployed would typically be in addition to PHE (responsible for identification, initial testing, contact tracing, convening outbreak control team, initial infection prevention and control advice):

In the table below is an indication of the type of resource that may be required:

Capacity	Resource
Local Authority Public Health	1.5 WTE PH consultants 2.0 WTE Public Health Specialist/Environmental Health Officer 1.0 WTE Advanced Public Health Practitioner/PH Registrar 1.0 WTE administration support 1.0 WTE data capture and analysis (Intelligence staff)
Local Authority Other capacity	1.5 WTE Communications Managers 2.0 WTE Adults Social Care 2.0 WTE Children's Services 1.0 WTE Health and Safety Manager Plus, CCG and NHSE working on their commissioned services
CCG capacity	1.0 WTE Infection Prevention and Control
NHS/mobile units	Testing capacity and its administration

In an escalated scenario (for example, double this) additional local resources would be required in the region of 50% more capacity.

We would need to draw on other public health staff, EHO staff, potentially PH nursing staff and seek mutual aid from other Local Authority public health and PHE staff.

We do not have specialist cleaning teams and would therefore need to access and rapidly deploy this support. This is something that is being reviewed at a regional level to resolve as a flexible resource across the South West as needed. We also do not currently have access to HP Zone (PHE clinical record system) to manage results, cases and contact tracing as PHE will still be managing the contact tracing element of outbreaks but working closely with the Local Authority as per current practice.

It is envisaged that the national Test and Trace service will be in place for 18 – 24 months. In such a protracted escalated scenario, additional resources as per above would be required within LA public health teams and increased co-ordination across the Council, with settings (schools, care homes, prisons, workplaces etc) with neighbouring Local Authorities, NHS, DHSC testing services and specialist cleaning teams.