COVID-19 Outbreak Control Plan

Date: 16/10/2020

THE ROYAL BOROUGH OF
KENSINGTON
AND CHELSEA

Contents

OUTBREAK CONTROL

List of Abbreviations

ASC	Adult Social Care
BAME	Black and Minority Ethnic
BHPB	Bi-Borough Health Protection Board
BHWB	Bi-Borough Health and Wellbeing Board
CCG	Clinical Commissioning Group
CT	Contact Tracing
CTAS	Contact Tracing Advice Service
DPH	Director of Public Health
HPT	Health Protection Team
IMT	Incident Management Team
JBC	Joint Biosecurity Centre
LCRC	London COVID-19 Response Centre
MTU	Mobile Testing Unit
OCOG	Outbreak Control Oversight Group
OMT	Outbreak Management Team
PBCT	Phone Based Contact Tracing
PCR Test	Polymerise Chain Reaction Test
PHE	Public Health England
RBKC	Royal Borough of Kensington and Chelsea
SOP	Standard Operating Procedure
SPoC	Single Point of Contact
STAC	Scientific and Technical Advisory Cell
WCC	Westminster City Council
WHO	World Health Organisation

OUTBREAK CONTROL

A.1.Executive Summary

Novel coronavirus (COVID-19) is a new strain of coronavirus first identified in Wuhan City, China at the end of 2019. By late January, the virus was present in the United Kingdom. On 23rd March 2020, the British Government imposed a lockdown across the country, banning all non-essential travel and severely limiting contact with people outside of your household.

As lockdown measures are relaxed, wide-scale testing and contact tracing are required to control the coronavirus rate of reproduction 'R' and reduce the spread of infection.

The NHS Test and Trace service went live on Thursday 28 May 2020. Local government plays a key role in NHS Test and Trace.

The Royal Borough of Kensington and Chelsea's Outbreak Control Plan details how the Council supports Public Health England in identifying and containing any local outbreaks, identified by NHS Test and Trace. Playing our part in this national effort is a key priority for this Council.

The plan forms part of the national COVID-19 management strategy led by central Government, consisting of testing individuals with symptoms of coronavirus, tracing their close contacts, containing outbreaks and enabling further research into the virus. It fully considers the needs of our diverse communities and recognises the shared nature of some of our council services and collaboration and close working with the Royal Borough of Kensington and Chelsea, as well as other local, regional and national agencies.

The plan sets out how the Council will:

1. Manage any outbreaks of coronavirus across our diverse communities and settings
2. Understand and rapidly and efficiently respond to any patterns of coronavirus as they emerge
3. Work closely with national and regional partners to ensure everyone who needs a test, has access to one
4. Build trust and confidence among our communities in using NHS Test and Trace
5. Protect our most vulnerable residents and prevent and mitigate any outbreaks within our high-risk settings
6. Ensure that any resident who needs to self-isolate and needs support from the Council – receives the assistance they need.

Our robust plan aims to protect everyone who lives, works and visits Kensington and Chelsea, who are our utmost priority. With it, we can ensure that our residents, businesses and visitors can safely return to life as close to normal as possible.

OUTBREAK CONTROL

A.2 Introduction

A.1.1 Background

1. 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.
2. On 23rd March 2020, the United Kingdom central government initiated a period of lockdown across the country. Many aspects of society were suspended to enforce social distancing, in order to manage the spread of the virus.

A.1.1 Aim

3. As restriction measures are implemented and changed according to infection levels, wide-scale testing and contact tracing is required to help reach and maintain a steady state of low level or no transmission of COVID-19 in the community. This plan forms part of a national COVID-19 management strategy led by central government, consisting of testing the population, contact tracing cases and containing outbreaks and enabling further research about the virus.
4. This plan works alongside the RBKC Contingency Plan for Major Incidents and Emergencies, the RBKC Pandemic Plan and the RBKC COVID-19 Tactical Plan, as well as regional and national plans.

A.1.2 Objectives

5. The objectives of this plan are to:
    1. Define the roles and responsibilities of local authority personnel in COVID-19 outbreak control in line with current legislation and in concert with the London Coronavirus Response Cell (LCRC). Unless specific powers exist, the Council's role will be to advise and encourage actions as required by LCRC.
    2. Outline how localised testing, contact tracing and containing and enabling will be conducted.
    3. Establish and integrate outbreak control governance structures into the existing response structures described in the RBKC Pandemic Plan, including means of escalation where required to the LCRC.
    4. Ensure there is a coordinated council response for internal and external communications.
    5. Identify and manage high risk locations and support vulnerable people.
    6. Outline the integration and management of local and national data.
    7. Document the council's adherence to the seven national themes.
    8. Document the council's adherence to the six-point London local authority response strategy.

A.1.3 Definitions

6. **Outbreak** – Two or more confirmed cases of COVID-19 where both are linked by time and place.
7. **Self-isolation if you have symptoms** – Any symptomatic person and all members of their household must remain at home. They must not go outside their home for any reason i.e. to work, school, or public areas, and do must not use public transport or taxis.
8. **Single suspected/possible case** – A person with coronavirus symptoms (fever, persistent new cough, and/or loss of taste/smell).

9. **Direct close contacts** – Direct face to face to face contact with a case for any length of time, including being coughed on or talked to. This will also include exposure within 1 metre for 1 minute or longer
10. **Contact** – A person who has been in close contact with someone who has tested positive for coronavirus within the previous 14 days. This person may or may not live with them.
11. **Test and Trace tier system** – Doctors and nurses are 'tier 2' clinical contact tracers; their role includes collecting lists of contacts. The lists are passed on to 18,000 lay 'tier 3' contact tracers, who speak to those who may have contracted the disease. The most complex cases are allocated to 'tier 1' tracers, consisting of experienced Public Health England (PHE) contact tracers.
12. **Single confirmed case** – A person who has tested positive for coronavirus.
13. **Single complex case** – A suspected or confirmed case of coronavirus where this is complicated factors for the community setting (e.g. within cohort of vulnerable people).
14. **Cluster**
    a) Two or more confirmed cases of COVID-19 among community members of the same grouping/activity, occurring within 14 days or;
    b) a few symptomatic (of COVID-19) individual requests for tests from several people in a locality or a common site or activity.
15. **Infectious period -** 48 hours prior to symptom onset to 7 days after, or 48hrs prior to test if asymptomatic.

A.1.3.1 Contact definitions for community setting

16. **Direct close contacts:** Direct face to face to face contact with a case for any length of time, including being coughed on or talked to. This will also include exposure within 1 metre for 1 minute or longer.
17. **Proximity contacts:** Extended close contact (within 1-2m for more than 15 minutes) with a case. In some scenarios this will mean a large group of people in a congregation or community group

A.1.3.2 Outbreak Setting Definitions

18. **Outbreak** – Standardly, an outbreak is two or more confirmed cases of the virus being detected in a single setting. However, an outbreak may also be declared at a lower, or higher number of cases depending on the setting.
19. **High risk** – Awaiting definition
20. **Community clusters outbreak** – Cases spread over three or more households identified in the preceding seven days within the same geographical area (defined as a Middle Super Output Area, approximately 7000 individuals) not known to be linked by an existing setting already being managed (care home/school/workplace etc).
21. **Care homes outbreak**
    a) If the home has a suspected new coronavirus outbreak or;
    b) It has been 28 days or longer since the last case and there are new cases.
22. **Schools and educational settings outbreak**
    1. Two or more confirmed cases of COVID-19 among students or staff in the school/college within 14 days or;
    2. An overall increase in sickness absence reporting where parents report illness with suspected COVID-19 (but where no tests have been done or results are available).

23. **Workplace outbreak** – One or more confirmed cases of the virus being detected in a single workplace setting.

24. **Hostels/rough sleepers** – Further guidance is awaited from Public Health England in relation to this cohort. Within a hostel it is anticipated to be two or more linked cases in a specified setting.

Plan Development

25. The Kensington and Chelsea Outbreak Control Plan centres around seven national themes as defined by central government:

    1. Planning for outbreaks in care homes and schools.
    2. Identifying and planning how to manage other high-risk places, locations and communities.
    3. Identifying methods for local testing to ensure a swift response that is accessible to the entire population.
    4. Assessing local and regional contact tracing and infection control capability in complex settings and the need for mutual aid.
    5. Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook.
    6. Supporting vulnerable local people to get help to self-isolate.
    7. Establishing governance structures led by existing COVID-19 Health Protection Boards and supported by existing Gold command forums and a new member-led Board to communicate with the general public.

26. In addition to the government's seven themes, this plan also centres around the *Six-Point London Local Authority Response Strategy* (Figure 1. The '6-Point London Local Authority Response Strategy' for local authority outbreak control.).

GO LIVE Point 1: Core requirements	Point 2: Vulnerable groups	Point 3: Community and economic impact	Point 4: Local partnership response	Point 5: Connecting and engaging communities	Point 6: London regional resilience
Establish a LA Contact Tracing Lead and WG	Identifying potentially vulnerable groups	Understanding local community and economic impact	Partnership engagement	Mitigating low take-up of the national model	Local and regional resilience
Focus on Outbreak Management	Understanding vulnerability	Community Impact Checklist	Joining-up local intelligence with partners	Understanding barriers to engagement	Potential voluntary secondment to LCRC
Establish a local Data Hub	Role of shielding and 'shielding plus' services	Workforce Impact Checklist	Developing joint-action plans with partners	Focus on vulnerable groups and personas	Mutual-aid arrangements
Workplaces and buildings				Baseline and enhanced communications	

Figure 1. The '6-Point London Local Authority Response Strategy' for local authority outbreak control.

27. These points are:

Point 1 Core Elements: The Local Authority model: core elements and structures. Core elements for engaging/co-ordinating with the national tracing model

1a) Identify a Local Authority Contact Tracing Lead (guidance strongly suggests that this should be the local Director of Public Health).

1b) Establish a local authority contact tracing working group (i.e. Local Authority Contact Tracing Lead, Public Health leads for infection control and outbreak management, Environmental Health services, Health and Safety, Communications, Representatives from key services linked to high-risk settings (ASC, Children's Services, Education, Housing),

consideration of representation of critical partners (Local CCGs, Health provider trusts, and the Police), Consideration of representation from local VCS and faith groups).

1c) Review local outbreak control readiness, processes and structures and begin considering undertaking scenario planning on how outbreaks will be managed within key settings (e.g. Care Home, Schools, and Hospitals etc.).

1d) Establish a local data-hub to co-ordinate and communicate local information and data on tracing and testing in the local area.

1e) Make workplaces and settings safe.

Point 2: Supporting and protecting vulnerable groups

2a) Consider specific residents and groups who may need additional support as a result of being asked to self-isolate. A number of groups have been identified (see main report) as potentially highly impacted by additional pressure arising from self-isolation.

2b) Understand local vulnerability and develop local approach to address these (NB. the Task and Finish group is working on a high-level impact assessment/checklist for Local Authorities to use/consider)

2c) Consider the role of *shielding* and *shielding plus* services going forward and how these can support local response.

Point 3: Understanding and mitigating wider community impact

3a) Understand and plan to mitigate impacts of extended scope of self-isolation in your area. These impacts include impacts on local economies, businesses and enterprises, community groups, essential services and workforce, and local enforcement. (NB. the Task and Finish group is working on a high-level community impact checklist as part of the toolkit to help identify gaps and key considerations).

3b) Develop/update local business continuity plans to prepare for scenarios where large proportions of the local workforce (especially those required to deliver critical face-to-face or in-office services).

3c) Additional considerations: local level sitreps (for high risk services), sharing of best practice, planning for the next phases of the easing of restrictions and regular engagement with critical local businesses in key sectors etc.

Point 4: Leading the local partnership response

4a) Ensure a ‘whole-area’ approach is taken to responding to the potential expansion of self-isolation and general increased risk as lock-down is incrementally eased. Consider inviting key partners to be part of the proposed Local Area Contact Tracing Working Groups (CCG, Police, VCS), supporting local area-based data hub to co-ordinate local information, and /or developing joint-action plans between the Council, CCG and police partners. More information is provided in Figure 5 on page 24.

Point 5: Connecting and engaging local communities

5a) Consider level or support are able to provide in supporting the local uptake and outreach of the national testing and tracing model. Develop understanding of the potential outreach and engagement gaps. Consider mitigating the risk of low-take up and engagement with hard-to-reach groups and communities.

Point 6: Building London regional resilience and mutual aid

6a) It appears highly likely variation between local authority areas may continue into the future and as such developing regional resilience within London appears to be a critical consideration e.g.

- Voluntary secondment of resource into LCRC (London COVID-19 Response Centre) to support rapid regional deployment of resource to areas of pressure and need.
- Establishment of more formal mutual aid and sit-rep reporting within localities in London.

A.1.4 Government's Test and Trace service

28. On the 28 May central government launched a national COVID-19 contact tracing (CT) service as part of the Test and Trace programme. It combines digital and phone-based CT approaches to identify cases and their close contacts so they can rapidly self-isolate.
29. The digital approach consists of two components[1]:
    a. An automated NHS app system for rapid symptom reporting, ordering of tests and targeted alerts to app users who have been in close contact with a symptomatic or confirmed COVID-19 app user.
    b. An invitation only web-based tool, the Coronavirus Contact Tracing and Advice Service (CTAS), to contact trace those not identified through the app.
30. A dedicated national phone-based contact tracing service (PBCT) has been established with 25,000 operators. This service is for individuals who cannot use the app or CTAS. All those who test positive, but without access to the app or CTAS, will be contacted by text message, email or a PBCT call handler.
31. These CT strategies are to be managed nationally.
32. Outbreaks (rather than individual cases) may be managed regionally. At a London level they are managed by the London COVID-19 Response Centre (LCRC).
33. The local authority will assist the LCRC in cases requiring more intervention, such as those in high risk settings or community clusters.
34. Additionally, the local authority will have a responsibility to address local issues as outlined in the 6-Point London Local Authority Response Strategy, such as:
    - Shielding;
    - Supporting vulnerable individuals and households to self-isolate;
    - Supporting high risk communities and groups;
    - The local economy;
    - Essential services and workforce issues.

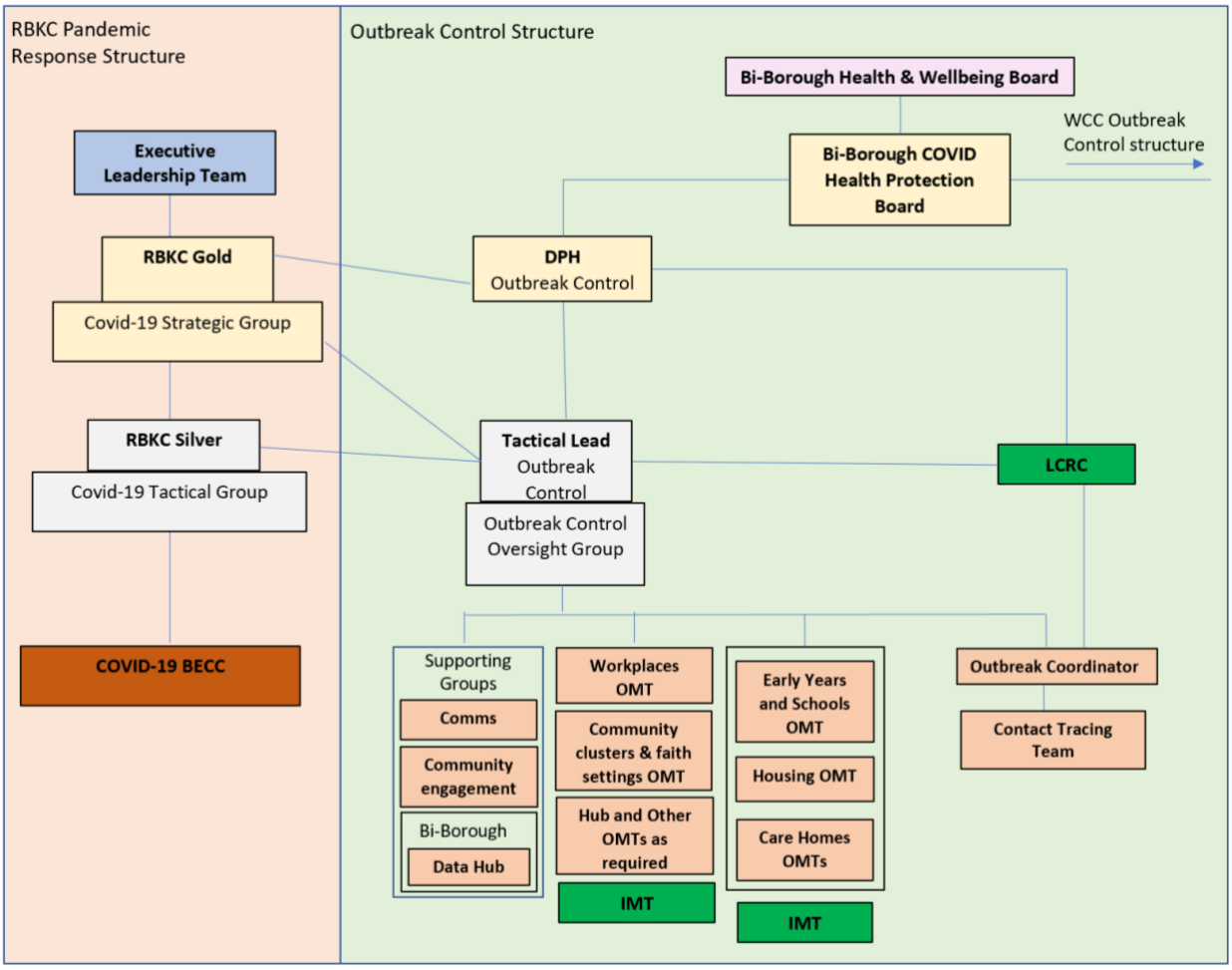
Outbreak Control Response Structure

A.1.5 Structure

35. The Outbreak Control chain of command runs parallel to the Pandemic Response chain of command. While the Pandemic Response command chain is operational, the Outbreak Control command chain feeds into it at strategic and tactical levels. However, if the Pandemic Response is demobilised, Outbreak Control can continue to operate as an independent structure.

[1] Both parts of the digital approach are to be launched in June 2020.

Figure 2. The command structures for the Pandemic Response and Outbreak Control. Blue lines show direct communication between roles.



A.1.5.1 London COVID-19 Response Centre (LCRC)

36. The LCRC was established in February 2020 to provide the pan London PHE COVID-19 acute response. It draws staff from all three Health Protection Teams (HPTs), other PHE London staff, specialty training registrars and a few other volunteers (mainly previous staff/registrars).
37. The LCRC managed contact tracing of all COVID-19 cases during the initial contain phase and currently manages COVID-19 new outbreaks (predominantly in care homes), cases and enquiries from a range of professionals and others. This is done through Incident Management Teams (IMTs).
38. The three London HPTs continue to manage all non COVID cases, outbreaks and enquiries.
39. There is a joint agreement between the LCRC and London Local Authorities for supporting the management of COVID-19 outbreaks in complex settings. This agreement is being kept under monthly review due to the rapidly changing regional situation.
40. The LCRC incident management process is as follows:

- Upon notification, the LCRC undertakes a risk assessment and give advice and provide information to the setting on management of the outbreak;
- LCRC will manage cases and contacts, and provide advice on testing and infection control;

- Either the LCRC will convene an Incident Management Team and request local authority support, or the LCRC will request the local authority establish an Incident Management Team.
- LCRC will inform the relevant local authority single point of contact (SPoC)
- The local authority will follow-up and support the setting to continue to operate whilst managing the outbreak, including, if required, support with infection prevention and control measures and PPE access;
- The local authority will support wider aspects of the response, such as support for any vulnerable contacts who are required to self-isolate, as per *London's 6 Pillar Local Authority Plan* (figure 1) and national *Seven themes of outbreak management* plan (outlined in paragraph 36).

41. The overarching joint approach to managing community clusters is as follows:

- The local authority or LCRC will receive notification from Tier 2 (national clinical contact tracers);
- The local authority will inform the LCRC SPoC/the LCRC will inform the local authority SPoC;
- The local authority will convene a local Incident Management Team (see section A.3.1.8 Outbreak Management Teams (OMTs) and Incident Management Teams (IMTs));
- The local authority will provide support to the community;
- LCRC will support the local authority in their risk assessment of and response to an identified community cluster.[2]

42. See A.4.2 Trace for more information.

A.1.5.1.1 Single Point of Contact

43. There is a single point of contact between the LCRC and the local authority to facilitate data flow, communication and follow up.

44. For shared situational awareness and resilience this is in the form of a shared secure mailbox, accessible by the Strategic Lead, Tactical Lead and the Outbreak Control Oversight Group (at the discretion of the Strategic Lead). Information arriving into the shared inbox is processed by the OCOG with oversight from the Deputy Director of Public Health/Strategic Lead. Information is then passed on to the relevant team.

A.1.5.2 Bi-Borough Health and Wellbeing Board

45. The Bi-Borough Health and Wellbeing Board (BHWB) provides the overview of the implementation of the Plan. It can hold the system to account to deliver the Plan, secure collaboration and enforce change and provides guidance to the Bi-Borough Health Protection Board to inform strategic and tactical decisions. The BHWB only offers advice on strategy and tactics, it does not make decisions.

46. The BHWB includes local authority elected members and Chairs of the CCGs as well as other health and social care partners.

47. All BHWB members can contribute to the board's deliberations, strategies and activities. In addition, all members (with commitment from their nominating organisations) will share ownership of the board and accountability to the residents and communities it serves.

[2] *Joint Agreement between the PHE London Coronavirus Response Centre and London Local Authorities for supporting the management of COVID-19 incidents and outbreaks, including those in complex settings – Version 5*

A.1.5.3 Bi-Borough Health Protection Board

48. The Bi-Borough Health Protection Board (BHPB) brings together partners from across the Bi-Borough to oversee and provide strategic support and assurance on the WCC and RBKC strategies for outbreak control.

49. The group is chaired by the Bi-Borough Director of Public Health. It reports to the sovereign borough Gold Group whenever those groups are active.

A.1.5.4 Outbreak Control Strategic Lead

50. The strategic lead is a Director or Deputy Director of Public Health. While the Pandemic Response structure is active, the Outbreak Control Strategic Lead feeds into the RBKC Gold group.

51. The Strategic Lead is the single point of contact for the LCRC, maintaining situational awareness with the Tactical Lead and the Outbreak Control Delivery Group through a secure shared mailbox.

A.1.5.5 Outbreak Control Tactical Lead

52. While the Pandemic Response structure is active, the Outbreak Control Tactical Lead contributes to tactical meetings as a member of the COVID-19 Tactical Group chaired by RBKC Silver. The Outbreak Control Tactical Lead chairs the Outbreak Control Oversight Group.

A.1.5.6 Outbreak Control Oversight Group

53. The Outbreak Control Oversight Group (OCOG) is a tactical level multi-agency group, chaired by the Tactical Lead. The group's role is to coordinate the local response to COVID-19 incidents and outbreaks, ensuring the 6 Pillar Local Authority Response strategy is met. This group is to meet exceptionally under direction of the Tactical Lead.

54. Decisions will be deferred to the Emergency Leadership Team if there is a significant impact to the community.

55. Membership should include multi-agency representatives and RBKC service area leads from:

- Interim Director of Public Protection – Chair and Tactical Lead
- Public Health
- Community Resilience and Engagement
- Communications
- Data Hub
- Environmental Health
- Housing Services
- Rough Sleeping Services
- Adult Social Care
- Children's Services
- OMT leads
- Resilience Team
- Clinical Commissioning Groups

And may also include representatives from:

- Testing
- Public Health England
- Police
- Voluntary Sector

A.1.5.7 Outbreak Management Teams (OMTs) and Incident Management Teams (IMTs)

56. Outbreak Management Teams (OMTs) maintain an overview of outbreaks and incidents in general settings. Incident Management Teams (IMTs) are convened to manage specific outbreaks in individual settings. OMTs are convened locally by the Tactical Lead with support provided by the LCRC, while IMTs are convened by the LCRC with support of the local authority. OMTs may take on the role of IMT where this is required locally and initially in the absence of PHE who may be responding to a larger outbreak or several outbreaks across London.
57. The Council has set up OMTs for higher-risk settings as follows: Care Homes; Schools/Early Years; Housing; Workplaces; Community settings. Care homes, schools/early years, and, housing OMTs operate Bi-borough whilst workplaces and community settings are sovereign. All are chaired by Public Health except for Workplace OMTs which are chaired by the Interim Deputy Chief Executive and Facilities Management.
58. The role of an IMT is to manage the operational response to a Covid-19 outbreak or incident.
59. In many outbreak settings, the LCRC will convene an IMT and request local authority participation.
60. Local Outbreak Management Teams will be activated by the Tactical Lead in consultation with the OCOG. The LCRC may also request that the council activate a Local IMT and the Tactical Lead in consultation with the OCOG can elect to use an existing OMT.
61. Local Outbreak Management Team membership may vary depending on the incident. The Chair of each will convene meetings with a core membership and invite others as necessary. The Chair of each OMT shall attend the OCOG. The OCOG will agree a standard Terms of Reference for the OMTs to adopt and each OMT will be responsible for developing and agreeing their setting-specific Standard Operating Procedures.
62. OMTs will maintain an Incident/Outbreak Log.
63. See A.1.8. Trace for more information on the role of IMTs.

A.1.5.8 Local Contact Tracing

64. The move to a localised contact testing system, integrated with the national programme, provides an opportunity for the Council to enhance the national system, and to identify where there may be links between cases and potential sources of infection. The Council can use the expertise and experience of our staff to target and ultimately control the spread of the virus through a locally tailored and appropriate response.
65. The intention is that the provision of a local contact tracing response (COVID-19) service will:
    - Improve contact tracing rates of individuals who have tested positive to a minimum of 80% [national target], with a local target of 90%. Many local authorities in the north of England have seen contact improving to 90-95% with full complete details in over 60% cases
    - Increase contact tracing of people who have had close, recent contact with an individual who has tested positive, including those from places the individual has visited.
66. The London wide contact tracing system was set up to facilitate data sharing and best practice among London boroughs. It uses a web-based tool, the Contact Tracing and Advice Service (CTAS) to input and host information on cases and contacts. This receives details of lab-confirmed cases of COVID-19 and triggers an automated pathway for follow up contact tracing.
67. The Council joined the London scheme at the beginning of September in order to implement a local track and trace system. The structure chart reflects the introduction of a locally supported contact tracing system.

68. The Council's Tactical Lead oversees the operation and the Outbreak Coordinator ensures there is a rapid flow of data from the LCRC and Public Health to OMT Chairs and the contact tracing team. The Council's Public Health team has a critical role in assisting in the management of the programme and supporting the Tactical Lead. Public Health will be required to provide the evidence needed to inform the activities of the contact tracing team. Public Health will also offer the necessary epidemiological advice to ensure that those activities are prioritised in areas of greatest need.
69. The contact tracing team will of course have direct access to the CTAS system and so will have real time information.

A.1.5.9 Bi-Borough Data Hub

70. The Data Hub is a Bi-Borough data management and surveillance system. It integrates data provided through OMTs/IMTs, the LCRC, Joint Biosecurity Centre, local health partners and the local authority, helping identify outbreaks and inform the response.
71. See A.6 Data Management for further detail.

A.1.5.10 Communications Lead

72. The Communications lead sits on the OCOG. They are responsible for ensuring the agreed communications objectives are implemented appropriately and effectively.
73. See A.5 Communications for further detail.

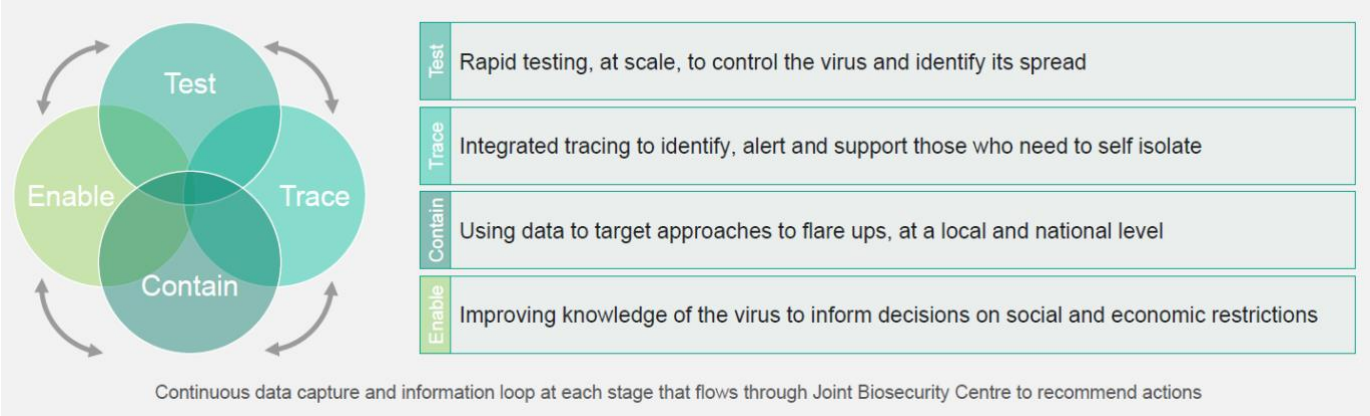
A.1.5.11 Community Engagement Lead

74. The Head of Community Empowerment is responsible for ensuring RBKC outbreak control meets the needs of our residents and local communities as well as facilitating the essential communication and information flow between the Council our residents and communities.

Outbreak Management: Test - Trace - Contain - Enable

75. The government's Test & Trace service is at the core of outbreak management. Testing individuals with symptoms, tracing their contacts, containing local flare ups and enabling the government and scientific community to learn more about the virus.

Figure 3. The government's COVID-19 Test & Trace Service to manage the virus upon easing of lockdown restrictions.



A.1.6 Public Health England Incident Levels

76. The government measures the COVID-19 pandemic according to PHE Incident Levels 1 to 5 (table 2).

Incident Level	Authority to assign response level
1. Local with limited public health impact	PHE Centre Director/Leader of Local Health Protection Service
2. Local with limited public health impact but greater than can be managed by one PHEC	PHE Regional Director (in consultation with the Director for Health Protection if appropriate)
3. Public health impact across regional boundaries or national. May require national co-ordination	PHE Director of Health Protection/Duty Director in consultation with the Chief Operating Officer
4. Public health impact severe. Requires central direction and formal interaction with Government	PHE Director for Health Protection in consultation with Chief Executive Officer/Duty Director and Chief Operating Officer
5. Catastrophic. Central direction and extensive commitment of resource.	PHE Chief Executive Officer/Duty Director

Table 1. PHE Incident Response Levels

77. Escalation or de-escalation through incident levels is driven by the nature, scale and complexity of COVID-19 incidents. Any incident response level can be changed following a review of the strategic direction and operational management of the pandemic. Table 2 describes the criteria for escalation and de-escalation.

78. Any changes to the incident response level will be authorised by the Incident Director (at that response level) following a discussion with the Director of Health Protection.

79. All response level changes will be communicated internally and externally to those involved in the response.

Criteria for escalation	Criteria for de-escalation
• Need for additional internal resources • Increased severity of the incident • Increased demands from partner agencies or other government departments • Heightened public or media interest • Increase in geographic area or population affected	• Reduction in internal resource requirements • Reduced severity of the incident • Reduced demands from partner agencies or other government departments • Reduced public or media interest • Decrease in geographic area/population affected

Table 2. Escalation and de-escalation criteria

80. For further information on PHE Incident Levels, see Public Health England's *Communicable Disease Outbreak Management Operational guidance* document.[3]

[3] Public Health England. (2014). *Communicable disease outbreak management: operational guidance.* Available at: https://www.gov.uk/government/publications/communicable-disease-outbreak-management-operational-guidance

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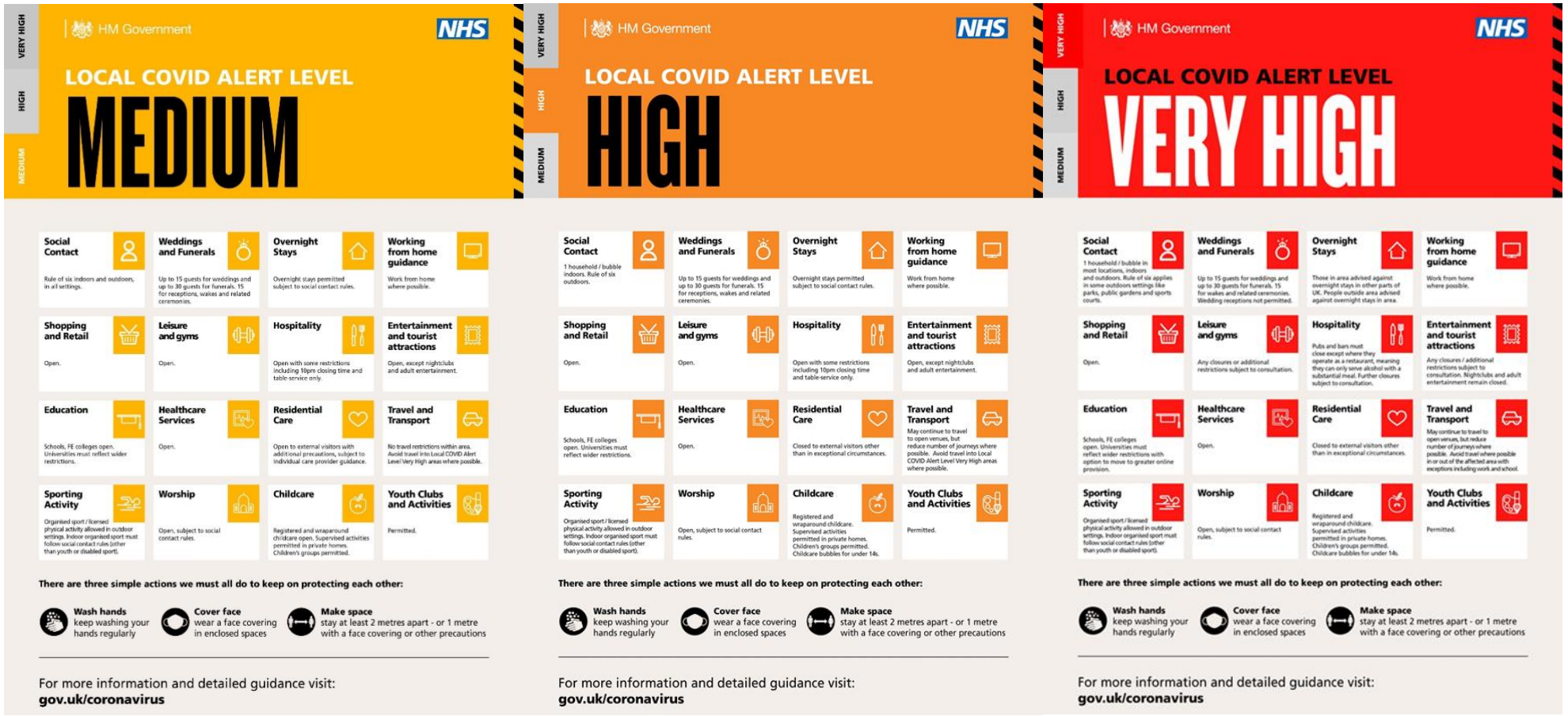
A.1.7 Covid Alert Levels

81. The Government has introduced three local COVID alert levels, Medium, High and Very High, which set out the information for local authorities, residents and employees about what to do and how to manage the outbreak, at the different levels of alert, within the Borough.



A.1.8 Test

82. Testing is a core element of disease control, rapid testing, at scale, across all regions of the UK enables the identification of infection.
83. If someone suspects they currently have COVID-19, they can take a test to check if they have the virus. This is called an antigen test (sometimes referred to as a virus swab or PCR test).
84. Antibody tests are used to detect antibodies to the COVID-19 virus to see if an individual has previously had the virus. The test works by taking a blood sample and testing for the presence of antibodies to see if the individual has developed an immune response to the virus. Antibody tests differ to virus swab (PCR) tests, which test to see if an individual currently has the virus.
85. As of 16 June 2020, antibody tests are currently only open to health and social care workers. Please see the GOV.UK guidance on antibody tests for the latest advice and information.
86. It's important to note that there is no strong evidence yet to suggest that people who are found to have had the virus and have antibodies develop long-lasting immunity which would prevent them from getting the virus again. Regardless of having antibodies, it is crucial people continue to follow social distancing and exercise good hand hygiene to prevent contracting the virus and/or passing onto others.
87. Within the borough there are currently no permanent testing facilities.[4] Testing can be accessed via postal home testing, at the mobile testing unit or by visiting one of five regional testing sites. Tests must be booked in advance on the GOV.UK website following the development of any COVID-19 symptoms.
88. Under the National Testing Programme there are currently five testing channels.

A.1.8.1 Mobile Testing Unit (MTU)

89. Deployment of the Mobile Testing Unit is arranged through the LLACC. The MTU is managed by the military.
90. As of mid-June 2020, there should be the capacity to deploy an MTU to each London borough every other day. There is to be a transition from a military to a commercial workforce between the end of June and the end of August 2020.
91. PHE are working on guidance for how to deploy MTUs to hot-spot areas identified through the Test and Trace programme.
92. The MTU does have a walkthrough option available, although this has limited capacity. This is unadvertised. Spaces are generally allocated mostly to symptomatic people and asymptomatic key workers.[5]

A.1.8.2 Pop Up Testing

93. Pop up testing sites can be established in local, fixed locations. These walk-in centres are an alternative for those with difficulty accessing MTUs.
94. Establishment of these units is down to the Tactical Lead in consultation with the OCOG.

A.1.8.3 Satellite Testing

95. Satellite testing centres can be set up at NHS Trust locations and care homes with particularly urgent or significant need.

[4] *As of June 2020*

[5] *As of June 2020*

A.1.8.4 At-Home

96. Home antigen test kits can be delivered to someone's home if they, or someone they live with has coronavirus symptoms. If eligible/available, a test will be posted to their home. Once completed, a courier will collect the test.

97. A testing kit can be requested via the GOV.UK website.

A.1.8.5 Regular Testing

98. Regular testing in high risk settings supports early identification and control of outbreaks, particularly through the identification of asymptomatic cases.

99. National guidance is expected imminently and a local arrangement through NHS North West London is beginning to provide regular testing for local settings.[6] Available testing capacity will be directed in response to local outbreaks.

A.1.9 Trace

100. When someone tests positive for coronavirus the NHS Test and Trace service will use dedicated contact tracing staff, online services and local public health experts to identify any close recent contacts they've had and alert those most at risk of having the virus who need to self-isolate.

101. In complex or high-risk settings local tracing may be required and would be carried out by local multi agency incident management teams.

102. Local teams will assess local and regional contact tracing capability in complex settings (e.g. identifying specific local complex communities, developing assumptions to estimate demand and options to scale capacity).

A.1.9.1 Complex Settings and outbreaks

103. The joint approach to managing **complex settings and outbreaks** is as follows:

1. LCRC will receive notification from Tier 2, undertake a risk assessment and give advice and provide information to the setting on management of the outbreak;
2. LCRC will manage cases and contacts, and provide advice on testing and infection control;
3. LCRC will convene an Incident Management Team (IMT) if required;
4. LCRC will inform the relevant local authority SPoC;
5. The local authority will follow-up and support the setting to continue to operate whilst managing the outbreak, including, if required, support with infection prevention and control measures and PPE access;
6. The local authority will support wider aspects of the response, such as support for any vulnerable contacts who are required to self-isolate, as per London's 6 Point Plan and national 7 themes of outbreak management plans.

104. **Complex or high risk settings may include, but are not limited to:** schools, care homes, fire stations, sheltered accommodation (including hostels, sheltered housing, women's refuge and youth provision), hotels, shops and shopping centres, transport hubs, museums, galleries, theatres, cinemas, sports grounds, restaurants, cafes, bars, pubs, clubs, gyms and leisure centres, hairdressers/beauty salons/barbers/tattoo parlours, places of worship, office blocks, children centres, community centres, day centres, adventure playgrounds, food banks, outdoor gyms, libraries, youth clubs.

[6] *As of June 2020*

A.1.9.2 Community Clusters

105. The overarching joint approach to managing **community clusters** is as follows:

1. The local authority or LCRC will receive notification from Tier 2
2. The local authority will inform the LCRC SPoC/LCRC will inform the local authority SPoC
3. The local authority will convene an IMT
4. The local authority will provide support to the community
5. LCRC will support the local authority in their risk assessment of and response to an identified community cluster.

	Setting						
	Care settings	**School & Early Years**	**Workplace**	**Primary care**	**Prison/custodial institutions**	**Homeless and/or hostel**	**Community cluster**
London Coronavirus Response Centre response	- Receive notification from Tier 2 - Gather information and undertake a risk assessment with the setting - Provide advice and manage cases and contacts, testing and infection control - Provide information materials to the setting - Recommend ongoing control measures - Convene IMT if required - Provide information to DPH and advice/recommendations for ongoing support						- Receive notification from Tier 2 - Support Local Authority in their risk assessment of and response to an identified community cluster
Local authority response	- Prevention work and respond to enquiries - Support vulnerable contacts who are required to self-isolate - Liaise with setting to provide ongoing advice and support for testing, communications, infection control and PPE - Participate in IMT if convened by LCRC - Local communications e.g. briefings for Councillors, local press inquiries, comms with the public - Liaise with CCG, GPs and other healthcare providers to provide ongoing healthcare support to setting						- Receive notification from Tier 2 - Convene OMT - Provide support to community which may include translated materials, support to self-isolate, advice and enforcement in line with existing powers - Liaise with the local CCG, GPs and other healthcare providers - Local communications (e.g. Cllr briefing, local press inquiries, comms with public)

Table 3. Summarised roles by setting (LAs and LCRC)

A.1.9.3 High Risk Settings – Standard Operating Procedures

106. Standard operating procedures (SOPs) for high risk or complex settings, including stakeholder roles and responsibilities, have been produced and are held by the Council.

A.1.9.4 Community Engagement

107. Community engagement is at the heart of the local authority outbreak management. The Council has developed its Community Engagement Approach alongside a borough-specific Equalities Impact Assessment. This includes consideration of activity to ensure public awareness of track and trace and build and maintain public trust. The approach reflects intelligence received from Public Health, as well as developments in Government messaging, and national and local insight and data.

108. In recognition of the disproportionate impact COVID-19 has on Black and Minority Ethnic (BAME) communities, the Community Engagement Approach has been developed in line with PHE's June 2020 review of disparities in the risk and outcomes of COVID-19, *Beyond the data: Understanding the impact of COVID-19 on BAME groups*. The review shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19.[7]

109. Given the knowledge and expertise that will be needed to conduct Covid specific community engagement effectively, a dedicated team of Community Development Officers is being established. They will be tasked and supervised by a coordinator at Team Manager level, complimented by alternates able to provide additional capacity. This team will be supplemented by Community Wardens, able to be pivoted at specific times. The Head of Community Empowerment will operationally manage this function.

110. The intention is that the team will offer coverage from 07:00-23:00 hours from Monday to Sunday (with in person core hours coverage 10:00-20:00 – Mon-Fri). This approach will be reviewed after two weeks of its launch to ascertain whether it is a proportionate response to events on the ground.

A.1.9.5 Supporting Vulnerable People

111. The Council's Community Hub provides support for those identified as required to self-isolate as a result of test and trace. This includes assistance with food shopping where no friends or family are available to help, collection of prescriptions and referrals to befriending services.

A.1.9.6 Rough Sleepers

112. Individuals within rough sleeping housing pathways or that are sleeping rough on the streets are recognised as particularly vulnerable. Furthermore, individuals who are clinically vulnerable or clinically extremely vulnerable will be within these cohorts. Consideration will need to be given to ensuring awareness of test and trace requirements in this cohort; facilitating testing and ensuring that individuals are able to self-isolate as required.

[7] Public Health England. (2020). *Beyond the Data: Understanding the impact of COVID-19 on BAME communities.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

A.1.10 Contain

113. The National Joint Biosecurity Centre will work with local authorities and public health teams in Public Health England (PHE), including local Directors of Public Health, to identify localised outbreaks and support effective local responses.

114. The National Joint Biosecurity Centre will utilise data to target approaches to flare ups, at a local and national level.

115. Following confirmation of a positive case in a high-risk place, location or community the National Joint Biosecurity Centre will work with local authorities and public health teams in PHE to deploy testing facilities. This may include the use of MTU or pop up testing locations.

A.1.10.1 Infection Control

116. In the event of a coronavirus incident or outbreak, infection control measures are likely to be implemented by the OMT/IMT. This may include:

- Enhanced hygiene;
- Deep cleaning;
- Decontamination;
- Restriction of access and movement.

117. Infection control methods implemented are decided by the relevant OMT/IMT.

A.1.10.2 Local Lockdowns

118. 'Local lockdowns' may be implemented as a method of infection control, by slowing down the spread of the virus in specific outbreak hotspot areas. As of June 2020, no guidance on local lockdowns has been provided to local authorities.

A.1.10.3 Supporting Isolated persons

119. The council is making contact with vulnerable residents and tenants and is also working with partners to proactively support rough sleepers. Residents who have serious underlying health conditions have been strongly advised by the government to follow 'shielding' measures and the council has robust processes in place to support this highly vulnerable group.

A.1.10.4 Health Protection: Legal Context

120. Local authorities (Public Health and Environmental Health) and Public Health England have the primary responsibility for the delivery and management of public health actions to be taken in relation to outbreaks of communicable disease under current legislation, in conjunction with the police where necessary. The legal context for managing outbreaks of communicable disease sits:

- With Regional Public Health Officers and Police Officers under schedule 21 of the Coronavirus Act 2020.
- With Public Health England under the Health and Social Care Act 2012.
- With Directors of Public Health under the Health and Social Care Act 2012.
- With NHS Clinical Commissioning Groups to collaborate with Directors of Public Health and Public Health England to take local action to assist the management of outbreaks under the Health and Social Care Act 2012.
- With Local Authorities under the Health Protection (LA Powers) Regulations 2010.

- With other responders' specific responsibilities to respond to major incidents as part of the Civil Contingencies Act 2004.
- With Chief Environmental Health Officers under the Public Health (Control of Disease) Act 1984.

A.1.11 Enable

121. This plan has been developed in line with the 'Enable' aspect of the government's response strategy. RBKC's Outbreak Control plan will assist in enabling the government to learn more about the virus, to explore how infection control measures can be further reduced.
122. Data gathered will contribute to improving knowledge of the virus to inform decisions on social and economic restrictions.

Communications

123. Sovereign borough information is required for this section
124. Public Health and Communications colleagues will continue to work extensively, alongside the North West London Public Health England Health Protection Team and the London Coronavirus Response Cell (LCRC), in promoting Test and Trace among our communities and in responding to any local outbreaks as they may occur.

A.1.12 Communication objectives

120. The objectives of the Council's communications plan are to:-

- Deploy communications that could help to save lives and keep people safe
- Support public health colleagues by sharing key messages in line with the local outbreak plan and when local outbreaks occur
- Be ready for a rapid response to any local outbreak
- Ensure stakeholders understand our local outbreak plans
- Reassure residents, businesses and stakeholders that protecting their health is our priority
- Proactively engage with residents, businesses and stakeholders to highlight increases in case numbers that could lead to an outbreak and ensure key messages are repeated and shared

121. The key messages which are being promoted externally are:

- We're working closely with the NHS, Public Health England, community leaders, and businesses to help prevent spread of the virus in the borough
- We have plans in place to help identify, manage and contain outbreaks in the borough
- If you have any Coronavirus symptoms make sure you get tested
- Wash your hands with soap for at least 20 seconds, if you cannot then use hand sanitizer
- Please ensure you are at least 2m from anyone outside your household
- Remember, hands, face, space, to protect lives and protect livelihoods Sign up for information and keep up to date

122. Test and trace and Outbreak Management communications will need to support this plan and protect the public's health in:

- Raising awareness of NHS Test and Trace among our local communities so they feel safe and reassured to use it
- Raising awareness of Test and Trace amongst seldom heard groups in Kensington and Chelsea
- Ensuring residents, businesses and key stakeholders are clear on their role in supporting Test and Trace

- Supporting public health colleagues by sharing key messages in line with the local outbreak plan and when local outbreaks may occur in Kensington and Chelsea
- Reassuring residents, businesses and stakeholders that protecting their health is our priority.
- Supporting Public Health to achieve 60% of Kensington and Chelsea residents download the Test, Track and Trace app when it is launched.

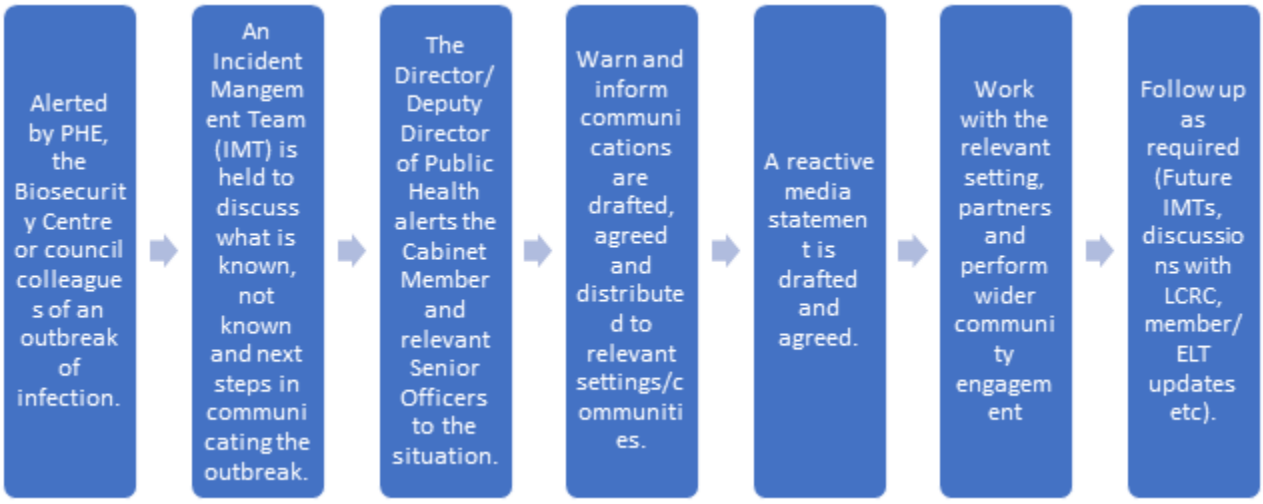
A.1.13 Communications in the event of an outbreak

123. In the event of an outbreak the communications messages will convey:

- Acting quickly will help control the outbreak
- Stick to measures to stop the outbreak

124. Communication in the event of an outbreak would flow as follows:

Figure 4. Outbreak communications flow.



A.1.14 Key messages

125. We will promote the following key messages for Test and Trace, and in the event of an outbreak among our residents, businesses and communities, alongside tailored messaging according to the situation:

Test and trace

- If you have symptoms book a test online at nhs.uk/coronavirus or call 119
- If you are called by Test and Trace to say you have been in contact with someone with Covid, you **must** self-isolate for 14 days
- If you develop symptoms during your 14 days isolation, you must isolate for a further 7 days from that point
- Together K&C, Protect Lives, Protect Livelihoods
- Main symptoms are high temperature, new continuous cough, loss of taste or smell. More information can be obtained here https://www.nhs.uk/conditions/coronavirus-covid-19/symptoms/
- Test and Trace is Government run system

Outbreak management

126. If there were to be an outbreak within the Borough the Director of Public Health (DPH) will decide what action, if any should be taken. This could include the closing down of a school, for example, if the

outbreak occurred there. If it is in Council property it will be easier for the DPH to close things down, however if it is a shop for example or a private block of flats it becomes more difficult as we currently do not have the additional powers to force premises to close down. The Government is receptive to providing more powers to local authorities if required.

Data Management

A.1.15 Joint Biosecurity Centre

127. The government has announced that it will be creating a Joint Biosecurity Centre (JBC) to bring together expertise and analysis to inform decisions on responding to Covid-19.
128. The JBC will lead a new biosecurity monitoring system. It will bring together epidemiologists with other analysts from across government to give ministers, via the chief medical officer, joined up advice on decisions about managing the disease.
129. The centre will have two main roles. The first is as an independent analytical function to provide real-time analysis about infection outbreaks. It will look in detail to identify and respond to outbreaks of Covid-19 as they arise. The centre will collect data about the prevalence of the disease and analyse that data to understand infection rates across the country.
130. Its second role is to advise on how the government should respond to spikes in infections – for example by closing schools or workplaces in local areas where infection levels have risen. Should UK government ministers decide to impose different restrictions in different areas and regions across England, it will be on the advice of the JBC.
131. The JBC will analyse intelligence related and set threat levels, which in turn will inform ministers' decisions on protecting the public.
132. The government will be using the Covid-19 alert level to inform decisions and to explain the level of disease risk to the public. There are five levels:

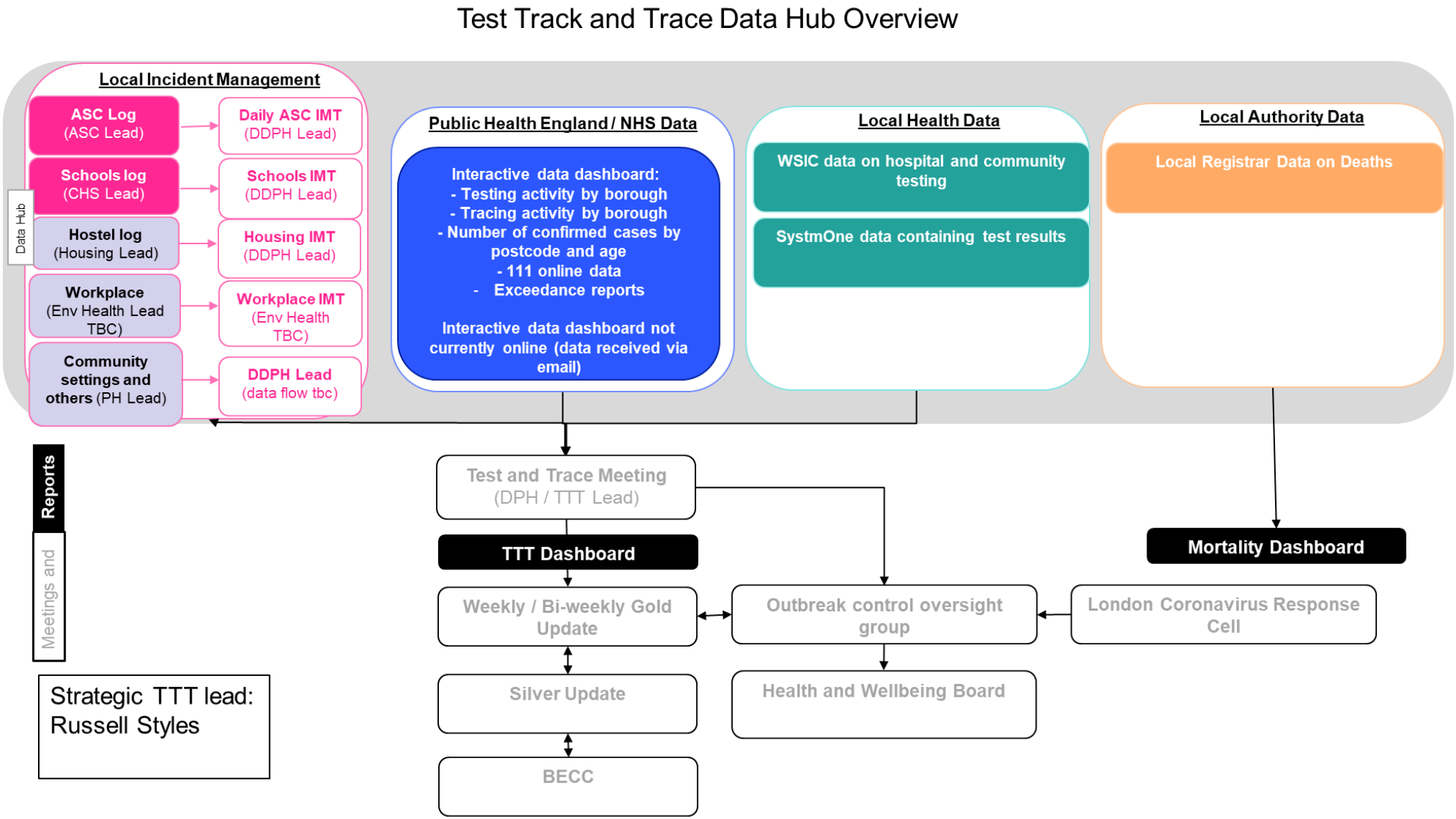
1. Level 1: Covid-19 is not known to be present in the UK
2. Level 2: Covid-19 is present in the UK, but the number of cases and transmission is low
3. Level 3: a Covid-19 epidemic is in general circulation
4. Level 4: a Covid-19 epidemic is in general circulation; transmission is high or rising exponentially
5. Level 5: as level 4 and there is a material risk of healthcare services being overwhelmed.

A.1.16 Bi-Borough Data Hub

133. The Data Hub acts as the single surveillance system for the Bi-Borough. It integrates local data provided through the IMTs; the NHS Test and Trace service; local health partners; and the local authority to support the identification of outbreaks in Kensington and Chelsea and inform the response.
134. The Data Hub is managed by Public Health and developed in collaboration with key partners. It serves as the Data Hub for both WCC and RBKC, with some data flows operating on a Bi-Borough basis while others are sovereign. Reporting is provided for each borough.
135. Figure 4 illustrates the data flows from these different sources and how it informs the appropriate governance and reporting structures

OUTBREAK CONTROL

Figure 5. Test, Track and Trace Data Hub Overview



OUTBREAK CONTROL

Local Authority Test and Trace Service Support Grant 2020/21

A.1.17 Grant Funding Allocation

136. The purpose of this ring-fenced grant is to provide support to local authorities in England towards expenditure incurred or to be incurred in the mitigation and management of local COVID-19 outbreaks.

137. The 2020/21 Public Health Grant allocations have been used as the basis for proportionality distributing the funding. An allocation of £1,932,848 was paid in one instalment in June 2020.

A.1.18 Grant Conditions

138. The Chief Executive & Chief Internal Auditor are required to certify the conditions of the grant have been complied the spend is with in conditions of the grant in line with the normal MHCLG reporting processes.

139. Failure to comply with any of the conditions the Minister of State may:

a) reduce, suspend or withhold grant; or

b) by notification in writing to the authority, require the repayment of the whole or any part of the grant.

A.1.19 Spend Projections

140.The table below provides a summary of the indicative spend, based on an initial assessment.

Grant	£ 1,932,848.00

Total Expenditure	**£ 1,932,848**	**%**
Community and Collaborative Programmes	£ 773,139	40%
Staffing	£ 811,796	42%
Operational/technology	£ 154,628	8%
Contingency	£ 193,285	10%

An approval process for spend against the grant has been introduced. All spend related to the ongoing Covid-19 response over the Autumn and Winter should be submitted to the Outbreak Control Manager (Stephen Brown) for consideration and will be subject to approval by Executive Director (ASC and PH) and Director of Financial Management in consultation with Lead Member for Adult Social Care and Public Health.

In addition to the £1.9m, the Council is in receipt of two other grant funding streams:

- £107,396 towards enforcement and compliance;
- £174,000 towards food and financial support.

A similar approval process is in place for these two grants through the Director of Financial Management and relevant Executive Director to agree spending plans against relevant grants.

Stand Down Arrangements

A.1.20 Standing Down

141. OMTs and IMTs make the decision to formally close an incident or outbreak based on the information available and risk assessments. All relevant partners and stakeholders should be informed of the decision and provided with information.

142. Formal termination of the Outbreak Control Plan must be agreed by the Strategic Lead and the Bi-Borough Health Protection Board, in consultation with key partners and stakeholders.

A.1.21 Debriefing

143. OMTs and IMTs should regularly record debrief points. These should be implemented as appropriate to improve the response.

144. When an incident or outbreak is closed, the OMT or IMT managing the incident must conduct a formal debrief. Lessons learned should be implemented as soon as possible.

145. Lessons identified throughout the overall Outbreak Control response must be documented, shared and acted upon. This should include a ‘hot debrief’ immediately after the end of the investigation/response and a ‘cold debrief’ within 4-6 weeks.

146. The following areas should be discussed as necessary, along with any other outbreak specific issues:

- The incident itself;
- Systems/procedures followed and feedback;
- Inter-agency working including successes and areas for improvement;
- Lessons identified.

147. Debrief summaries and documentation should be shared with all partners as appropriate.