

Revised Bexley COVID-19 Local Outbreak Management Plan (LOMP) 2021

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Date	28.04.2021
Approved by	
Signature	
Date	
Version	2.4

Document Control

Version Control

Version	Date	Issued to:	Owner's Name
Draft 0.3	01.07.20	LBB Corporate Leadership Team	Anjan Ghosh
2.1	14.03.21	LBB Corporate Leadership Team	Anjan Ghosh
2.2	22.03.21	Draft sign-off at HWB/ OEB	Anjan Ghosh
2.3	31.03.21	SEL Assurance at SEL DsPH IMT	Anjan Ghosh
2.4	29.04.21	Post SEL Assurance – edited with feedback	Anjan Ghosh

Change Control

Version	Date	Summary of Change	Owner's Name
2.1	14.03.21	New additions based on the updated national Contain framework, especially the following new areas (and subsequent headings under these): <ul style="list-style-type: none"> • Local Outbreak Plan themes • Core aspects of the end to end Covid-19 response • Areas of development since last outbreak plan 	Anjan Ghosh
2.2	21.03.21	Minor corrections, addition of the Outbreak Identification and Rapid Response framework (OIRR), and added definition of enduring transmission and key contributory factors	Anjan Ghosh
2.3	29.03.21	Minor additions taking into account individual borough feedback from PHE and DHSC	Anjan Ghosh
2.4	28.04.21	Added sections on risk and mitigations	Anjan Ghosh

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Executive summary

1. This is a revised draft document that describes the high-level plan that London Borough of Bexley is setting out for Covid-19 Local Outbreak Management. This is an iterative process and coincides with the Government publishing an updated Contain Framework in March 2021.
2. This is to be regarded as a “plan for a plan”. More detailed work is currently underway to develop specific aspects of the Plan especially around the new areas described in this document.
3. The final sign-off will be through the Health and Wellbeing Board on 22nd March 2021.
4. The COVID-19 Local Outbreak Management Plan (LOMP) establishes processes for and capacity to prevent and respond to Bexley residents infected with SARs-CoV-2 virus and outbreaks in local public settings known to be at high risk of transmission of the virus (e.g. schools or care homes).
5. Our local approach to outbreak management in Bexley has been consistent and remains faithful to the first principles of Test, Trace, Isolate and Contain – with the additional element now of ‘Vaccinate’. Of course, Non- Pharmaceutical Interventions (NPIs) continue to remain a critical part of this approach.
6. Since the last Plan the following **changes** have been made:
 - The control strategy and approach to outbreak management is underpinned by a wider range of tools, rules and technologies - this provides more depth and breadth to the approach taken.
 - Further objectives have been added in relation to surge testing, living safely with Covid, Covid-19 vaccination, and health inequalities.
 - Additional governance structures have been added, which strengthen the existing structure.
 - Significant **new sections** on:
 - a. Vulnerable and under-served communities
 - b. Communications and engagement
 - c. Surveillance
 - d. Data integration and information sharing
 - e. Community testing
 - f. Contact tracing and enhanced contact tracing
 - g. Support for self-isolation
 - h. Responding to Variants of Concern (VOC)
 - i. Action on enduring transmission
 - j. Ongoing role of Non-Pharmaceutical Interventions (NPIs)
 - k. Interface with vaccines roll out
 - l. Activities to enable ‘living with COVID’ (COVID secure)
 - m. Resourcing
7. Our LOMP is based on the legal duties of local authorities to protect the health of the residents from infectious risk.
8. It combines the London strategic approach and priorities into 4 work streams:
 - 1) Protect and Prevent; 2) Outbreak Response; 3) Engagement and communication; 4) Surveillance and Monitoring.
9. It builds on existing strong partnerships and mutual aid schemes developed during the earlier phases of the Pandemic.
10. It builds on learning from the previous year in addressing the Covid-19 risks including building trust between partner organisations, Bexley residents and specific communities.
11. It will monitor the local COVID-19 situation and implement mitigations to address local risk threatening efficiency of the early detection and control of COVID-19 infections in Bexley.

Background – Local COVID-19 situation and reason for revision

12. At the time of revising this plan we have been through two waves of the Pandemic and three national lock-downs, the first of which started a full year ago. The second wave started from Sept/Oct 2020 onwards and only now is tapering off and with it the end is in sight for the easing of the third national lockdown through the Prime Ministers roadmap¹.
13. The first cases of COVID-19 in Bexley were reported on 9th March 2020.² There have been 21,933 cases in Bexley (i.e. total number of people with at least one positive COVID-19 test result, either lab reported or lateral flow device, since the start of the pandemic), giving a crude rate of 8,833.7 per 100,000 population, as of 14th March 2021. This compares with a London case rate of 7,847.7 per 100,000 population and an England case rate of 6,615.8 per 100,000 population, since the beginning of the pandemic.³
14. As of 14th March 2021, there have been 621 registered deaths reported of Bexley residents involving COVID-19.⁴ This gives a crude death rate of 250.1 per 100,000 population, compared with a London crude rate of 204.4 per 100,000 population and an England rate of 219.0 per 100,000 population.⁵
15. In January 2021 Bexley had the second highest case rate in London at one stage, and during the peak of the second wave was consistently in the top five or six worst affected boroughs in London. In late October-early November last year, case rates in Bexley accelerated alarmingly, contrasting sharply with the rest of London where the rates were plateauing, and SE London where the rates were falling. This prompted detailed analysis by our Surveillance and Monitoring Team in conjunction with PHE to understand the genesis for this escalation. We discovered that Bexley was mirroring virtually identical escalation patterns in North Kent, especially in Dartford. This uncovered the phenomenon of Home County effects on Outer London Boroughs resulting in greater awareness across the region.
16. Subsequently it has also become clear that the escalation in Bexley at that time, was associated with the Variant of Concern that originated in Kent. The Kent variant is up to 70% more transmissible than the original Covid-19 strain that had affected the UK and is associated with higher mortality rates.⁶ This explains to a great extent why Bexley has had higher case rates and deaths from Covid-19.
17. The single biggest determinant for disparity in Covid-19 outcomes is age, and previous research by PHE on risk and outcomes of Covid-19 has shown that people aged 80 years or older were 70 times

¹ <https://www.gov.uk/government/news/prime-minister-sets-out-roadmap-to-cautiously-ease-lockdown-restrictions>

² GOV.UK Coronavirus (COVID-19) in the UK website (2021). Cases by specimen date. Available at:

<https://coronavirus.data.gov.uk/details/cases> [Data extracted on 14th March 2021].

³ GOV.UK Coronavirus (COVID-19) in the UK website (2021). Cases by area (whole pandemic). Available at:

<https://coronavirus.data.gov.uk/details/cases> [Data extracted on 14th March 2021].

⁴ Public Health England (2021). Covid-19 Situational Awareness Explorer (Power BI). COVID-19 Mortality. Data Summary [Data extracted on 14th March 2021].

⁵ Public Health England (2021). Covid-19 Situational Awareness Explorer (Power BI). COVID-19 Mortality. Data Summary [Data extracted on 14th March 2021].

⁶ <https://www.who.int/csr/don/21-december-2020-sars-cov2-variant-united-kingdom/en/>

more likely to die from Covid-19 than those under 40 years of age.⁷ In Bexley 8.2% of our population is aged over 75 years, which is significantly higher than London (5.5%) and SE London (5.4%).⁸

18. Bexley has the lowest per capita Public Health Grant allocation in London, and this brings to the fore the underlying health inequalities in Bexley and the pre-existing lack of investment in Public Health infrastructure. There is a vital need for increased focus and funding for Public Health and health services in Bexley.
19. The current system in place to address the Pandemic in Bexley is as resilient as it can be given the limitations in funding. However, maintaining future resilience especially with redeployed Council staff returning to their core duties, will be challenging without continued and further funding.
20. The experience so far has been that national lock-downs are highly effective in bringing down case rates and community transmission. In January 2021, the case rate in Bexley reached a peak of around 1319 per 100,000 population and Bexley was at one point the second worst affected borough in London. Currently almost three months into the third national lockdown the case rate is 28.6 per 100,000 and Bexley is the fifth least affected borough in London.
21. During this Pandemic many lessons have been learned and this will continue in the coming months. There has been universal recognition of the central role of Local Government in Pandemic response and the importance of 'Place-Based' and hyperlocal approaches in managing various aspects of Covid-19. New tools, rules and approaches have also been developed that have fortified the armoury of options to combat this Pandemic – from new testing options and technologies, to more nuanced and evidence-based approaches to settings based outbreak management, to new data and surveillance methods and assets, to continually evolving communication and engagement approaches and resources, to enhanced contact tracing, to the (likely) game-changing intervention of Covid-19 vaccination (in addition to non-pharmaceutical interventions – NPIs – like the appropriate use of PPE, social distancing and handwashing).
22. Bexley's performance in the NHS Covid-19 Vaccination Programme has been outstanding. Bexley is among the top three performers in London and one of our PCNs (APL) has been recognised as the top performing PCN in the country.
23. All these changes have culminated in an update of the national Contain framework that was first issued in June 2020 and now published in March 2021. With it, therefore it is only right to review and revise our Local Outbreak Management Plan (LOMP) and the current document reflects additional content from the updated national Contain framework.

7

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

⁸ Office for National Statistics (ONS, 2021). Mid-year population estimates (MYE) for 2019 available at: [Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland - Office for National Statistics](#)

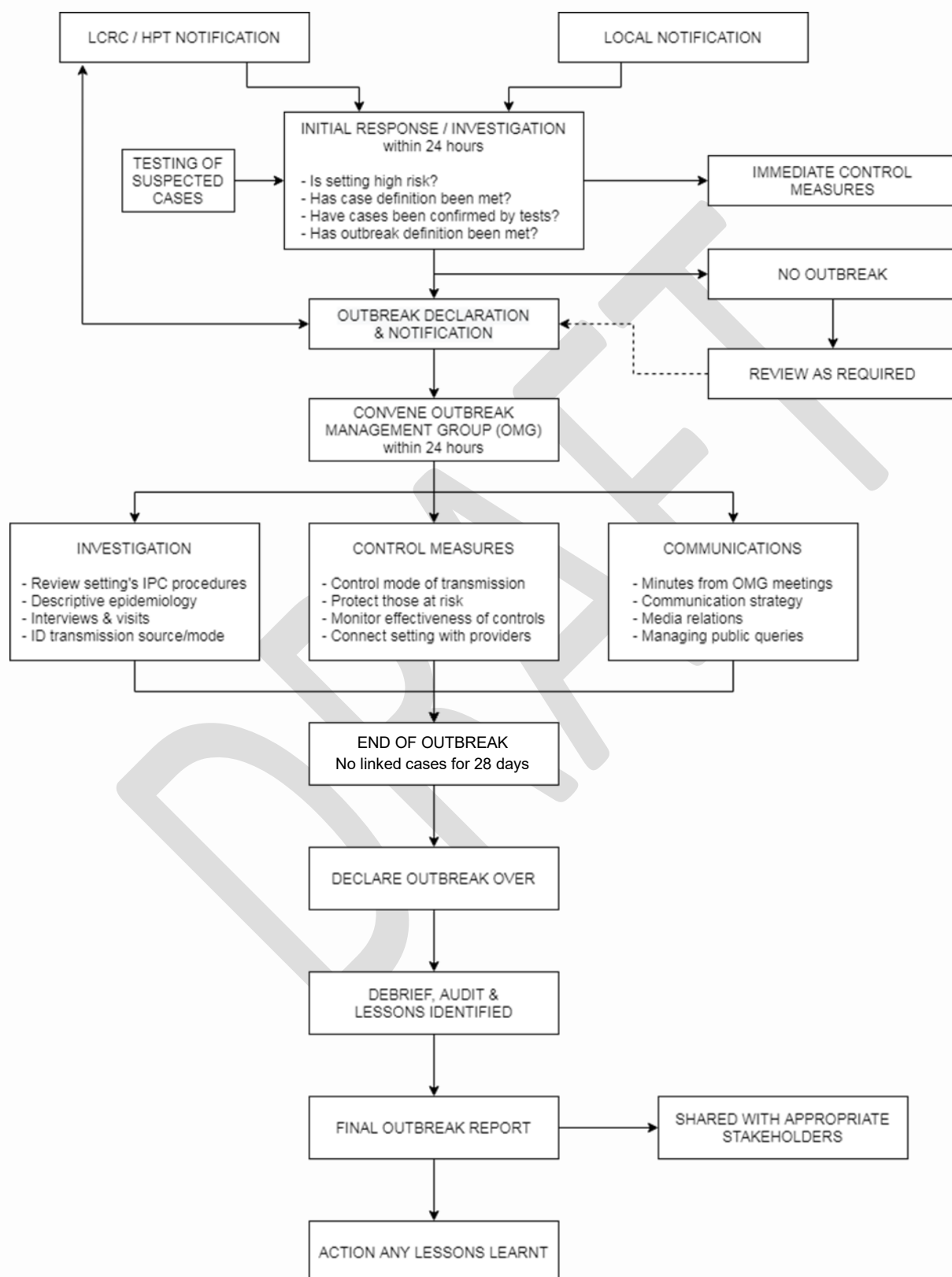
Control strategy and approach to outbreak management

24. **Principles:** Our local approach to outbreak management in Bexley has been consistent and remains faithful to the first principles of **Test, Trace, Isolate and Contain** – with the additional element now of **'Vaccinate'**. Of course, **NPIs** are also a critical part of this approach and will continue to remain so.
25. **Overall approach:** The overall control strategy and approach to outbreak management is to **vaccinate** as much of our population as per the JCVI (Joint Committee on Vaccinations and Immunisations) priority cohorts as possible, whilst maintaining an extensive network of **testing to rapidly detect** new cases of Covid-19, and **contain further spread** of infection through self-isolation of cases, effective **contact tracing** and **self-isolation** of contacts, and stringent **infection control and risk assessment** measures. All the while emphasizing NPIs and the **Hands-Face-Space** message. Linked with this are effective **communications and engagement** particularly with our residents.
26. **Testing landscape:** In Bexley symptomatic PCR testing is offered through our four Local Testing Sites (LTSs) and MTU (Mobile Testing Unit), and asymptomatic testing through our Mass Testing Centre at the Civic Office offering LFD (Lateral Flow Device) Testing and our Neighbourhood Rapid Testing programme delivered through a number of local community pharmacies, in addition to a mobile rapid testing bus which also promotes Covid-19 vaccination.
27. **Outbreak Identification and Rapid Response (OIRR):** This framework (see Appendix 1) helps our team (PHE/LAs) to detect and respond to local Covid-19 outbreaks effectively and quickly. It optimises and builds on existing cluster detection and response processes by working with positive test cases to help identify where and when they are likely to have been infected and taking rapid action to prevent wider community transmission, utilising enhanced contact tracing and timely and specific data to support risk-based interventions locally.
28. **Outbreak response protocol:** The outbreak response protocol is adapted from PHE's Communicable Disease Outbreak Management Operational Guidance⁹ as depicted in figure 1 below. This outlines the steps we follow in managing an outbreak in a given setting.
29. **Setting-specific Outbreak Control Plans:** We have identified 10 categories of high-risk settings in Bexley and have in place setting-specific Outbreak Control Plans (OCPs) for each of these. The OCPs have been co-produced with setting-specific stakeholders, and there is a rolling programme to update these OCPs whenever national guidance is revised or changed.
30. **Public Health Response Cell:** Since March 2020, London Brough of Bexley's DPH (Director of Public Health) stood up a local outbreak response cell called the C-19 Public Health Response Cell (PHRC) in the Council, with Public Health technical experts in managing outbreaks and infection control.
31. **Roles and responsibilities:** There are clear distinctions between roles and responsibilities for Local Authority and LCRC (as well as other agencies such as DfE) which are highlighted in subsequent sections of this document.

⁹

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/343723/12_8_2014_CD_Outbreak_Guidance_REandCT_2__2_.pdf

Figure 1 : Covid-19 Outbreak Response Protocol



32. **Working together on outbreak management:** In general, the process for locally managing an outbreak in a setting such as a school or a care home involves the local PHRC working closely with LCRC (London Coronavirus Response Cell, PHE), council partners (for example in adult social care, education or food safety and trading standards), setting owners and residents, to investigate the outbreak, contain it and ensure infection control measures are in place to prevent future outbreaks.
33. **Working together across boroughs:** There is very close working across boroughs in relation to the Covid response, at the London level, as well as sub-regionally in South East London – this is at the level of Directors of Public Health, Directors of Adult Social Care, Local Authority Chief Executives and Council Leaders, and between the NHS, Local Authorities and other agencies such as Metropolitan Police, the Military, Charities and Voluntary Sector.
34. **Working together with Kent:** Additionally, we have close cross-boundary relations with Kent colleagues and counterparts especially in relation to Dartford which Bexley shares a boundary with.

Legislative and organisational basis

35. The legal context for managing outbreaks of communicable disease which present a risk to the health of the public requiring urgent investigation and management sits
 - a. With Public Health England under the Health and Social Care Act 2012,
 - b. With Directors of Public Health under the Health and Social Care Act 2012,
 - c. With Chief Environmental Health Officers under the Public Health (Control of Disease) Act 1984,
 - d. With NHS Clinical Commissioning Groups to collaborate with Directors of Public Health and Public Health England to take local action (e.g. testing and treating) to assist the management of outbreaks under the Health and Social Care Act 2012,
 - e. With other responders' specific responsibilities to respond to major incidents as part of the Civil Contingencies Act 2004.
36. COVID-19 is a serious and imminent risk to Public Health and Secretary of State for Health and Social Care has issued urgent regulations providing further powers to limit onward transmission of the virus that causes it. The Health Protection (Coronavirus, Restrictions) (England)(No. 4) Regulations 2020 ("the No. 4 Regulations")¹⁰ confers new powers to Government and Local Authorities, specifically around:
 - Restrictions on movement
 - Restrictions on gatherings
 - Business closures and restrictions
 - The exceptions: businesses permitted to remain open
 - Further business exceptions
 - Enforcement, offences and fixed penalty notices
37. NHS England is responsible for ensuring control of the spread of infection in prisons and custodial institutions, co-ordinating with local PHE Health Protection Teams.

¹⁰ https://www.legislation.gov.uk/uksi/2020/1200/pdfs/uksi_20201200_en.pdf

Bexley's Local Outbreak Management Plan – aims & objectives

38. **Aim:** To prevent COVID-19 transmission in Bexley, helping a return to safe community and social life and restarting our economy

39. **Objectives:**

- a. Establish measures to prevent transmission and protect vulnerable residents (risk assessment, easy access to testing, ensure timely and effective identification and notification of contacts; support to cases and contacts).
- b. Manage outbreaks in the community (identify and mitigate negative impacts of control measures)
- c. Establish local surveillance and intelligence (timely and effective monitoring, build local intelligence).
- d. Support the management of outbreaks in complex settings with PHE.
- e. Develop and if indicated, implement, plans for “surge testing” of Variants of Concern (VOCs).
- f. Support our residents to live safely with Covid-19 and help create Covid-secure environments for example in workplaces, retail and hospitality sectors, and leisure facilities.
- g. Support the NHS Covid-19 Vaccination Programme and establish additional local vaccination delivery models (Mass Vaccination Centre(s) and mobile vaccination provisions).
- h. Identify and address Covid-19 related inequities and inequalities in Bexley.

Bexley's Local Outbreak Management Plan Strategic Framework

40. The diagram below describes the framework around which we will build our local outbreak response. It combines the London strategic approach and priorities into 4 work streams:

1. Protect and Prevent;
2. Outbreak Response;
3. Engagement and communication;
4. Surveillance and Monitoring.

Each workstream has specific roles described in the boxes. In the centre are examples of focal areas for preventing potential outbreaks and managing them.

Figure 2: Framework of Bexley's Local Outbreak Management Plan



Local, regional and national leadership roles

Table 1: Overall leadership at local, regional and national levels

Level	Place-based leadership	Public Health Leadership
LOCAL	<p><i>LA CE, in partnership with DPH and PHE HPT to:</i></p> <ol style="list-style-type: none"> Sign off the Outbreak Management Plan led by the DPH Bring in wider statutory duties of the LA (e.g. DASS, DCS, CEHO) and multi-agency intelligence as needed Hold the Member-Led Covid-19 Engagement Board (<i>or other chosen local structure</i>) 	<p><i>DPH with the PHE HPT together to:</i></p> <ol style="list-style-type: none"> Produce and update the Outbreak Management Plan and engage partners (DPH Lead) Review the data on testing and tracing and Vaccine uptake data Manage specific outbreaks through the outbreak management teams including rapid deployment of testing Provide local intelligence to and from LA and PHE to inform tracing activity DPH Convenes DPH-Led Covid-19 Health Protection Board (a regular meeting that looks at the outbreak management and epidemiological trends in the place) Ensure links to LRF/SCG

REGIONAL	<p><i>Regional team (PHE, JBC, T&T, London councils and ADPH lead</i></p> <ul style="list-style-type: none"> a) Support localities when required when required on outbreaks or specific cases or enduring transmission or substantial cross-boundary b) Engage NHS Regional Director and ICSs c) Link with Combined Authorities and LRF/SCGs d) Have an overview of risks issues and pressures across the region especially cross-boundary issues 	<p><i>PHE Regional Director with the ADPH Regional lead together</i></p> <ul style="list-style-type: none"> a) Oversight of the all contain activity, epidemiology and Health Protection issues across the region including vaccine uptake b) Prioritisation decisions on focus for PHE resource with Las or sub regions c) Sector-led improvement to share improvement and learning d) Liaison with the national level
NATIONAL	<p><i>Contain SRO and PHE/JBC Director of Health Protection</i></p> <ul style="list-style-type: none"> a) National oversight for wider place b) Link into Joint Biosecurity Centre especially on the wider intelligence and data sources 	<p><i>PHE/JBC Director of Health Protection (including engagement with CMO)</i></p> <ul style="list-style-type: none"> a) National oversight identifying sector specific and cross-regional issues that need to be considered b) Specialist scientific issues e.g. Genome Sequencing c) Epidemiological data feed and specialist advice into Joint Biosecurity Centre

Role of the local authority and LCRC in Pandemic response

Table 2: Roles of local authority and LCRC in Pandemic response

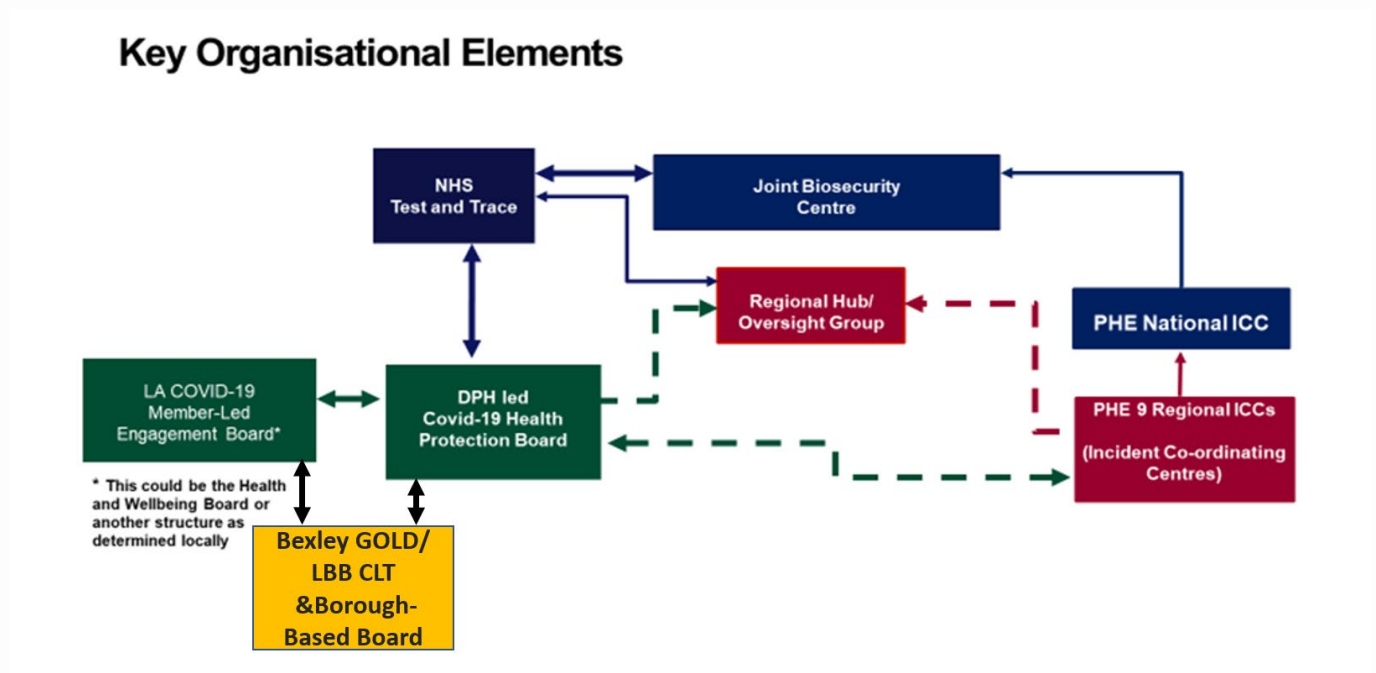
	PHE LCRC	Bexley
<p>Setting-specific outbreak i.e. Care settings, School and Early Years, Workplace, Primary care, Prison/custodial institutions, Homeless and/or hostel</p>	<ul style="list-style-type: none"> • Receive notification of cases and clusters via several different routes • Overview and • investigate and manage cases and clusters in high priority settings • Review and update resources • Provide advice and support • Provide advice and support around contact tracing, isolation, infection control practices, COVID safe environments and testing etc including written resources. • Attend IMT if required • Develop and provide communications to stakeholders • Liaise with CCG, GPs and other healthcare providers to 	<ul style="list-style-type: none"> • Receive notification of cases and clusters via several different routes • Investigate and manage cases and clusters in settings. • Provide advice and support around contact tracing, isolation, infection control practices, COVID safe environments and testing etc including written resources. • Chair IMTs if required • Develop and provide communications to stakeholders • Liaise with CCG, GPs and other healthcare providers to provide ongoing healthcare support to setting

	provide ongoing healthcare support to setting	
Case and contact investigation management	<ul style="list-style-type: none"> • Receive notifications of cases via clinical leads / local authority leads if meet the criteria as agreed in national test and trace protocols • Investigate and manage high risk cases and contacts as per local SOPs 	<ul style="list-style-type: none"> • Receive notifications of cases via national test and trace route • Investigate and manage cases and contacts as per local SOPs • Escalate to LCRC/HPT if meets criteria as agreed in national test and trace protocols • Provide support packages as required
Enhanced contact tracing (Cluster) investigation and management	<ul style="list-style-type: none"> • Overview of cluster identification and management • Overview management of priority settings • Attend IMTs if required 	<ul style="list-style-type: none"> • Investigate, identify priority clusters • Manage clusters as per relevant settings SOPs • Chair IMTs if required
VOCs (or other cases of concern)	<ul style="list-style-type: none"> • Investigate and manage initially VOC/VUI etc cases and contacts • Liaise with LA contact tracing for help with no contact cases • Investigate and manage any identified settings • Advise and support LA IMT to investigate and manage VOCs/VUIs cases and clusters with enhanced case and contact tracing, and targeted testing (community or setting focussed) including surge testing 	<ul style="list-style-type: none"> • Investigate and manage VOC/VUI etc cases and contacts – at present those lost to follow up • Establish and lead IMT to investigate and manage VOCs/VUIs cases and clusters with enhanced case and contact tracing, and targeted testing (community or setting focussed) including surge testing

Pandemic response governance

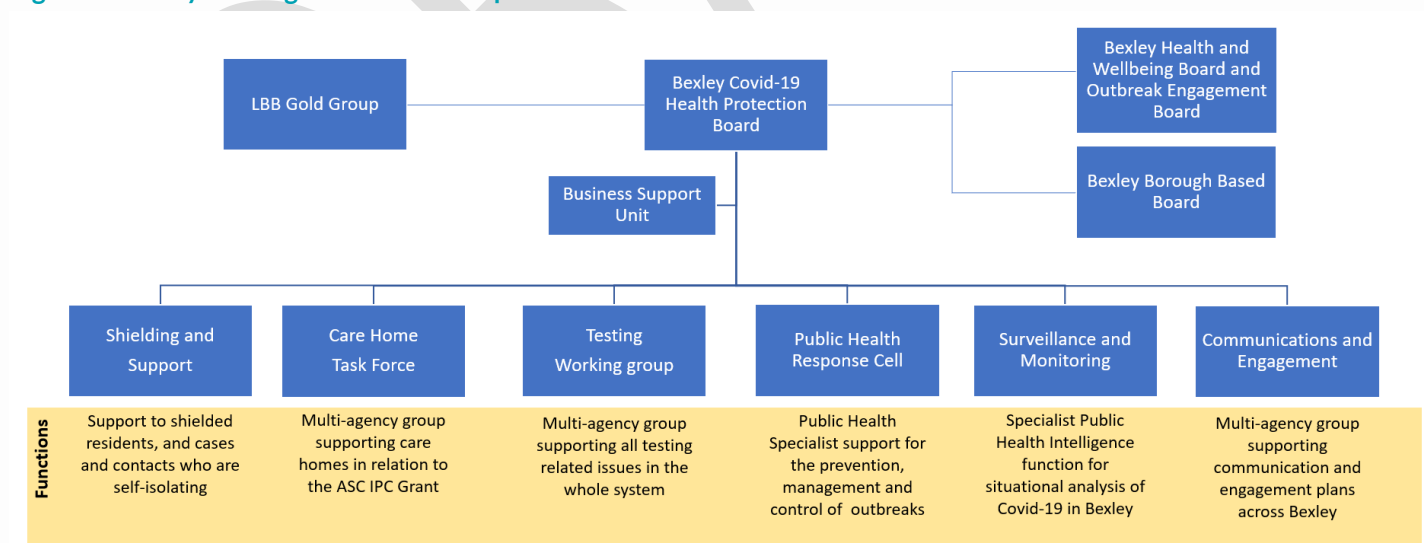
41. The diagram below depicts the overall governance arrangements for the system of NHS Test and Trace, from the national level (blue boxes), to the regional London-wide structures (red boxes), to the local structures at Bexley level (green and yellow boxes).

Figure 3 : Key high-level organisational elements of NHS Test and Trace



42. The diagram below summarises Bexley's governance and operational structures/ functions that underpin our Covid-19 Pandemic response. Whilst 'shielding and support' is not a discrete operational group like the rest are (task forces/ working groups/ workstreams) it is an important function in the Council.

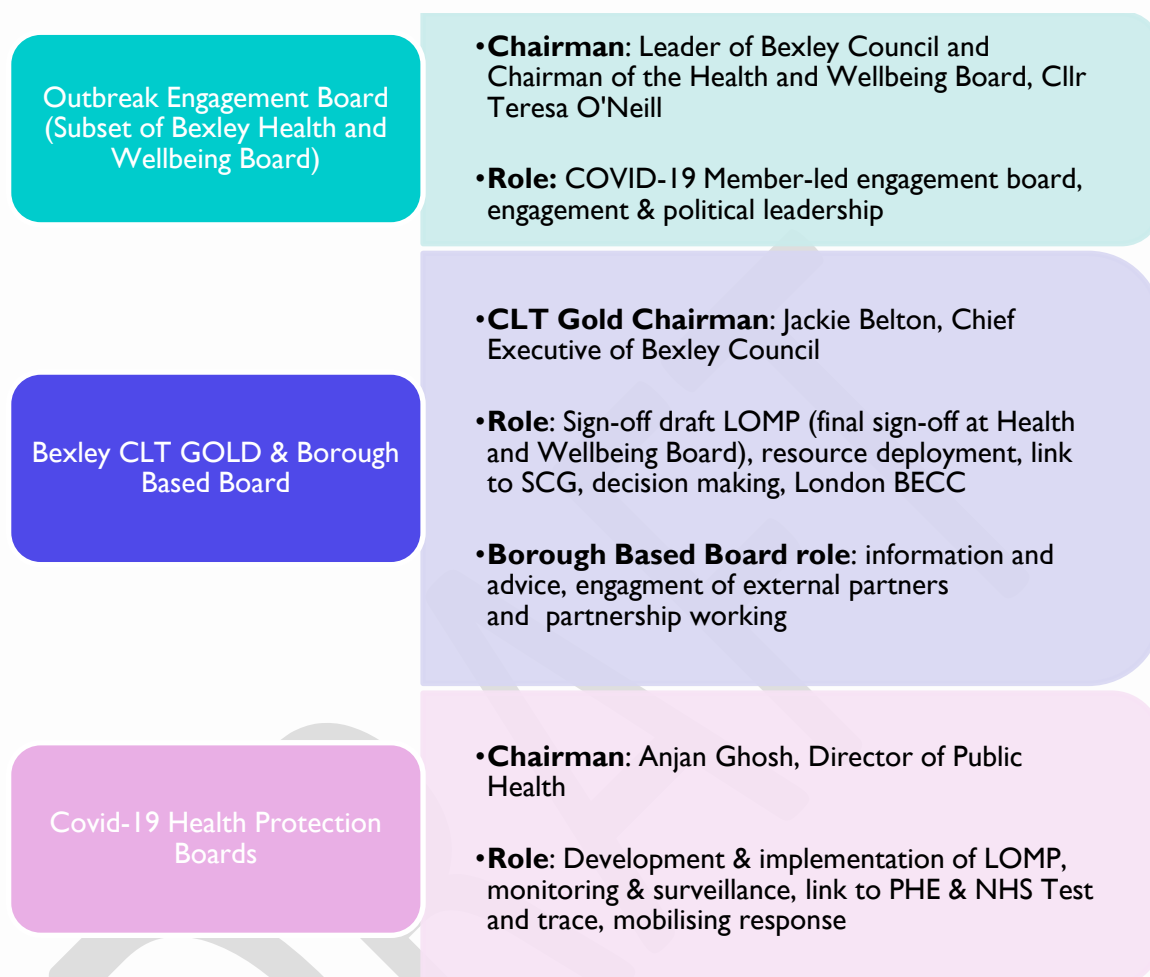
Figure 4: Bexley's local governance and operational structures



LBB – London Borough of Bexley
 ASC – Adult Social Care
 IPC – Infection Prevention and Control

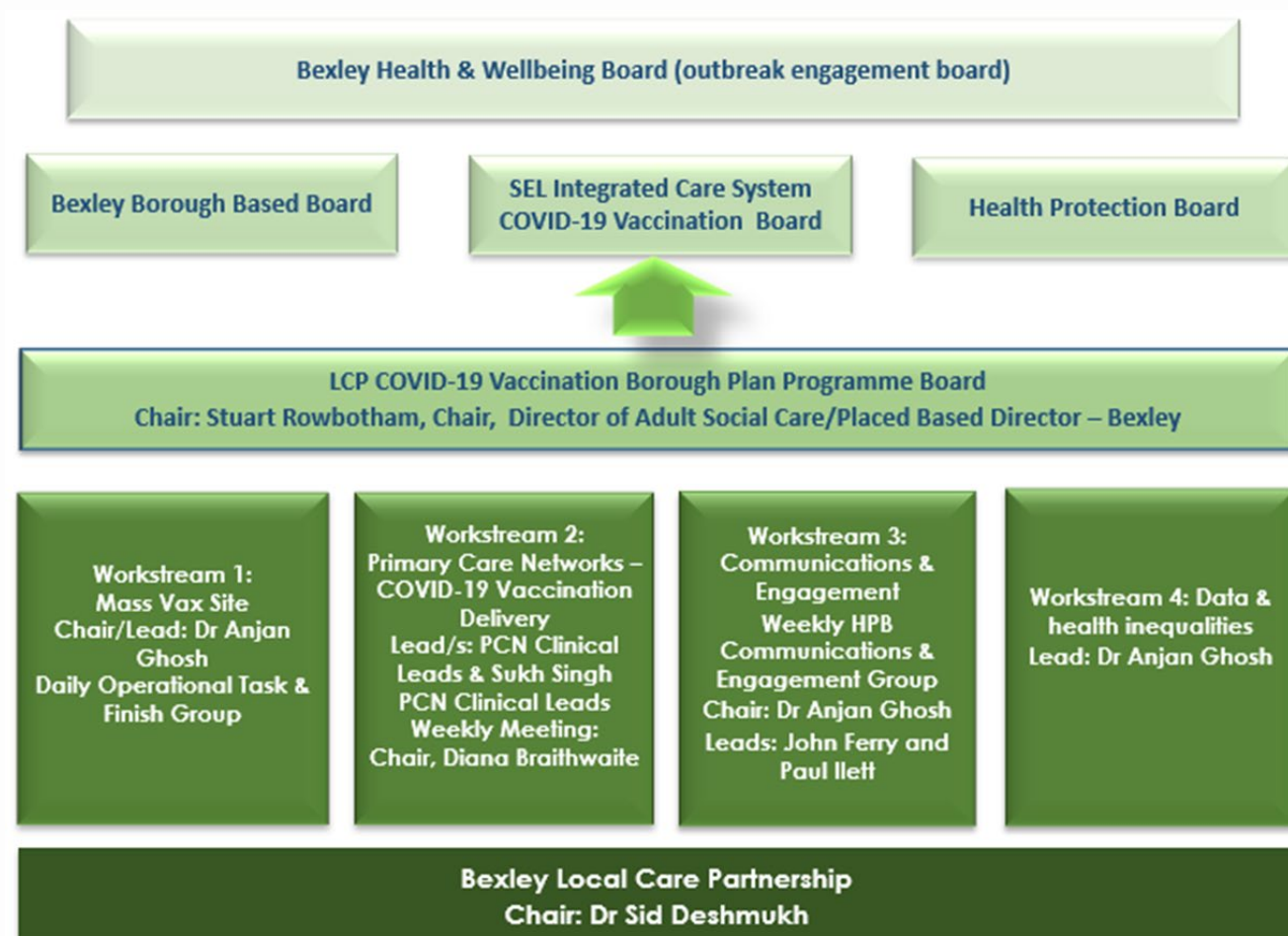
43. The diagram below depicts further details of the local governance and the main functions for each level of governance:

Figure 5: Local Governance arrangements in Bexley



44. Since February 2021 the Council has been closely involved in the NHS Covid-19 vaccination programme and local structures and governance have been established to support this, as depicted in the figure below. The local governance and leadership for this work is led by the Borough Director in Bexley, supported by the Director of Public Health and the Borough Director of Operations, and sits with the LCP Covid-19 Vaccination Programme Board under which there are four key workstreams: Mass Vaccination Site, Primary Care Vaccination, Communications and Engagement, and Data and Health Inequalities. In the interests of not mushrooming many additional groups, the last two are contained in the pre-existing Covid-19 workstreams (in figure 4) of Communications and Engagement, and Surveillance and Monitoring respectively.

Figure 6: Bexley Covid-19 Vaccination governance



High-risk workplaces (including healthcare, prisons and education settings), communities and locations

45. As mentioned earlier, we have identified 10 categories of settings that are at risk of outbreaks and further spread into the wider community. These include adult social care settings such as care homes, day centres and domiciliary care, educational settings such as early years, primary and secondary schools, 6th form and FE colleagues, and other higher education settings, retail and hospitality sector, food processing and non-food factories and units (especially in the North of Bexley), and various community settings. Bexley does not have any prisons, and nor does it have an Acute NHS Trust based within the borough, although Queen Elizabeth Hospital in Greenwich is in proximity and is one of our main acute hospitals followed by Darent Valley Hospital in Kent.
46. For each of these settings we have developed outbreak control plans (OCPs) which have been co-produced with setting-specific stakeholders, and there is a rolling programme to update these OCPs whenever national guidance is revised or changed.
47. Part of the process involves not only engaging setting-specific stakeholders in developing the OCPs but also assuring they carry out risk assessments especially if they have been shut for a period and

intend to open, or when guidance relevant to them changes, and that appropriate IPC measures and other measures are in place to ensure they are Covid secure.

Vulnerable and under-served communities

48. Following the release of the PHE report on disproportionate impact of COVID-19 in June 2020, particularly amongst Black, Asian and minority ethnic communities, London Directors of Public Health have responded with health and care partners in many ways, setting examples of best practice:

Local

Examples of work that Bexley has implemented following the Public Health England seven recommendations include:

- Community engagement with culturally specific COVID-19 Public Health messaging through community champions. Bexley now has 425 community champions actively supporting the work.
- Local conversations amongst council staff on racism and health inequalities following the death of George Floyd in the US in May 2020, especially through our BAME workers forum with actively visible support from the Council Chief Executive and senior leadership.
- Behavioural insights research on attitudes towards the COVID-19 vaccines, questions and fears among diverse communities – this is on-going work through Bexley Health Watch and through funding that NHS South East London CCG has provided recently to address vaccine hesitancy, unwarranted variations in vaccine uptake and inequalities in Bexley. See below for our planned projects currently underway to tackle this.
- Engaging with local communities on COVID-19 vaccine uptake in a culturally sensitive way through social media, webinars, community champions and health care professionals, and translated comms.

The Bexley plan (to tackle inequalities in Covid vaccination) was developed in collaboration with the Bexley Local Care Partnership, building on our joint Communications and Engagement Vaccine Programme Strategy. It is underpinned by insights from SEL and local Public Health data, surveys and intelligence from Healthwatch Bexley. There are five key interventions:

1. **Vaccine outreach** – Paid door knockers, an outreach bus(es) and developing online resources. Prioritised based on data and local insight.
2. **Effective conversations Training** – training around 50 community leads and 50 local workforce to be able to have purposeful conversations with residents and services users around vaccine hesitancy. Includes peer-to-peer training, seminars and webinars led by the British Society of Immunology, in partnership with Bexley Voluntary Services Council (BVSC), and other Local Care Partnership organisations.
3. **Deep Dive - younger residents** – Focussed project to understand the reasons for vaccine hesitancy among 18-35-year olds, explore how these might be addressed and design a bespoke comms & engagement approach, with an aim to mitigate the potential risk of low take up from these groups.
4. **Deep Dive - health inequalities** – Focussed project to understand more about hesitancy and barriers to accessing health care and services amongst under-served communities who traditionally suffer poorer health outcomes within Bexley. Will assist future design of communications and engagement.
5. **Homecare Workforce** – Working with homecare providers to break down the barriers to vaccine take-up.

Sub regional (through integrated care systems)

- ADPH London, PHE London and GLA organised 'light touch' peer review of COVID-19 Local Outbreak Management Plan in July 2020 at STP/ICS level with London Directors of Public Health from local authorities to facilitate shared learning and continuous improvement. Discussions that were had during the peer reviews included community engagement and comms, particularly vulnerable groups
- In March 2021 PHE London, ADPH London and NHSE/I London will develop a London Health Equity Delivery Group to be a key vehicle in implementing a standard approach to health equity across London where possible, bring together ICS leaders and regional partners to share practice and align priorities in addressing inequalities. This Delivery Group will report to the Health Equity Group (see next slide)
- Additionally, in SE London in partnership with the six Directors of Public Health, NHS SEL CCG has convened an Equalities Vaccination Task Force, chaired by the Bromley Borough Director with representation from each of the six SEL Public Health teams.
- SEL ICS has also convened a programme of work under the Population Health and Inequalities Board which oversees three 'cogs' / workstreams on population health management, prevention and inequalities, and maximising assets. The SRO for the prevention and inequalities workstream is the DPH of Bexley, and the work is being developed focussing in the short and intermediate term on the Vital 5 (Smoking, Hypertension, Obesity, Mental Health and Alcohol), and in the longer term on tackling structural inequalities.

Regional level (pan-London)

- In August 2020, the London Health Equity Group was formed to provide leadership and coordination to ensure health equity is central to all London level partnership transition and recovery strategies and the London Vision. The aim of the group is to:
 - Oversee the refresh of the Mayor's Health Inequalities implementation plan
 - Promote and support collaboration and action at neighbourhood, borough and ICS/STP level
 - Put in place enabling work identified by local partnerships as helpful to their joint work
 - Provide visible systems leadership and advocacy on health equity issues for Londoners
 - The Health Equity Group has a wide membership including health and care partners, voluntary and community sector, and faith groups
 - In February 2021, ADPH London released a position statement in supporting Black, Asian and minority ethnic communities during and beyond the COVID-19 pandemic. This statement highlights racism as a Public Health issue, given the immediate and structural factors that have impacted ethnic minorities, with intentions to develop an action plan to mitigate any further widening of inequalities in 21/22, focusing on five themes. The themes will be aligned with partner organisations priorities for the London Health Equity Delivery Group, and development and delivery of actions will be reported to the London Health Equity Group.
49. **Emerging priorities** that are being addressed on inequalities during and beyond COVID-19 are:
- Improved access to vaccination data between NHS and local authorities to help inform understanding of vaccine access and hesitancy as the NHS vaccination programme continues to rollout with additional priority cohorts
 - Recovery planning and understanding the wider impacts post second wave in responding to health inequalities, which have which have been highlighted by the higher than London and England rates of Covid cases and deaths, as outlined in paragraphs 13-18 above. With major challenges around childhood and adult obesity, mental health, substance misuse, cardiovascular diseases - health factors that are associated with increased risk of Covid and poor outcomes, it is important that we respond to the health needs of our residents
50. Bexley is also part of a Pan-London initiative, **London COVID-19 Find and Treat Service (F&T)**. It is delivered by a team from University College Hospitals and is jointly funded by all of London's Local Authorities and the Greater London Authority (GLA) for rough sleepers, homeless hostels, hotels, night-shelters, pay to sleep, large houses in multiple occupation (HMOs) and daycentres.
51. The Find and Treat service provides the following for rough sleepers, homeless hostels, hotels, night-shelters, pay to sleep, large houses in multiple occupation (HMOs) and daycentres:
- a. **Outreach testing and contact tracing:** Telephone clinical triage and on-site testing triggered by reporting of symptomatic cases, testing of contacts and immediate infection control advice on site liaising with the London Coronavirus Response Cell (LCRC).
 - b. **Variants of concern (VOC):** Should VOC postcode surge areas include any homeless or inclusion health settings F&T can support local surge testing.
 - c. **Training and support:** Provision of training for testing and contact tracing for key local staff (e.g. nominated street outreach workers, and others with key trusted relationships).

- d. **Sentinel screening:** Testing residents and staff of high-risk locations (e.g. prioritised based on size, shared facilities etc) to actively monitor the level of asymptomatic carriage. VOC testing data will be collated with sentinel testing.
 - e. **Vaccination:** Vaccination of the homeless population and support to address wider healthcare needs (NHS funded)
52. Find and Treat are also funded (via NHSE) to provide outreach testing and contact tracing to asylum hotels in London (funded until end March 2021). The service is currently working through the future delivery model needed (beyond 25th June 2021 when current funding ends) in anticipation of continuing infections and potentially outbreaks, particularly as vaccination uptake in this group is challenging. It will continue to collaborate with local authorities across London to understand and address the ongoing needs for these populations.

Communications and engagement

53. From the outset communications and engagement (C&E) was identified as a critical part of the local Pandemic response. A C&E workstream was established in July 2020 which has evolved into a multi-agency group across the Council, CCG, Primary Care, NHS Community Trust, Housing Developers, Bexley Healthwatch and voluntary sector. The workstream reports to the Health Protection Board and is accountable to the Outbreak Engagement Board.
54. We have a detailed communications and engagement plan which is an iterative and living document, being revised as the Pandemic progresses to include more details on testing related C&E, and now on Covid vaccination for which we have developed a further plan. All these documents are aligned with national, regional and sub-regional plans, and are underpinned by the Keep London Safe campaign and resources.
55. The work is supported by two Community Engagement Officers who helped to establish a programme of Community Champions. Currently there are around 425 community champions, including many elected members and officers. A microsite was also developed on the Council website for this: <https://www.bexley.gov.uk/coronavirus-covid-19/community-champions>
56. Our elected members have and continue to play a critical role as trusted community leaders, to help to disseminate information, dispel myths and misconceptions, and engage with residents.
57. We have a main landing page on the Council website on all information relating to Covid-19, which is widely appreciated and accessed by large numbers of residents and stakeholders: <https://www.bexley.gov.uk/coronavirus-covid-19>
58. We have a Council microsite for testing aligned to the local offer on testing and for booking to our Mass Testing Site at the Civic Office: <https://www.bexley.gov.uk/coronavirus-covid-19/services-status/local-covid-testing-centres>
59. A Council microsite also helps residents with trusted information and FAQs on Covid-19 vaccination: <https://www.bexley.gov.uk/coronavirus-covid-19/services-status/covid-19-vaccines>
60. Another microsite that provides residents and stakeholders with trusted information on Covid-19 data through a public facing dashboard which can be found through the main Covid-19 landing page, sample of which is: <https://www.bexley.gov.uk/coronavirus-covid-19/coronavirus-guidance-and-support>

61. Our approach utilises every conceivable channel from websites, to social media, to print media, leaflets, newsletters, magazines, webinars, JCDecaux billboards, digital displays, community champions, and now the Covid bus etc., to disseminate messages and gather insight, as well as to engage with our residents, community leaders and faith groups, and specific groups experiencing inequalities.
62. NHS SEL CCG also has a dedicated microsite for Covid-19: <https://selondonccg.nhs.uk/what-we-do/covid-19/>
63. The next step of our communication plan is to ensure residents and stakeholders are fully aware and understand the Government's roadmap to easing the national lockdown and can access the information they need and answer any questions they may have.

STEP 1 8 March		STEP 2 No earlier than 12 April At least 5 weeks after Step 1	
EDUCATION 8 MARCH <ul style="list-style-type: none"> Schools and colleges open for all students Practical Higher Education courses 		EDUCATION <ul style="list-style-type: none"> As previous step 	
SOCIAL CONTACT 8 MARCH <ul style="list-style-type: none"> Exercise and recreation outdoors with household or one other person Household only indoors 		SOCIAL CONTACT <ul style="list-style-type: none"> Rule of 6 or two households outdoors Household only indoors 	
BUSINESS & ACTIVITIES 8 MARCH <ul style="list-style-type: none"> Wraparound care, including sport, for all children 		BUSINESS & ACTIVITIES <ul style="list-style-type: none"> All retail Personal care Libraries & community centres Most outdoor attractions Indoor leisure inc. gyms (individual use only) Self-contained accommodation All children's activities Outdoor hospitality Indoor parent & child groups (max 15 people, excluding under 5s) 	
TRAVEL 8 MARCH <ul style="list-style-type: none"> Stay at home No holidays 		TRAVEL <ul style="list-style-type: none"> Domestic overnight stays (household only) No international holidays 	
EVENTS <ul style="list-style-type: none"> Funerals (30) Weddings and wakes (6) 		EVENTS <ul style="list-style-type: none"> Funerals (30) Weddings, wakes, receptions (15) Event pilots 	

STEP 3

No earlier than 17 May

At least 5 weeks after Step 2

 **EDUCATION**

- As previous step

 **SOCIAL CONTACT**

- Maximum 30 people outdoors
- Rule of 6 or two households indoors (subject to review)

 **BUSINESS & ACTIVITIES**

- Indoor hospitality
- Indoor entertainment and attractions
- Organised indoor sport (adult)
- Remaining accommodation
- Remaining outdoor entertainment (including performances)

 **TRAVEL**

- Domestic overnight stays
- International travel (subject to review)

 **EVENTS**

- Most significant life events (30)
- Indoor events: 1,000 or 50% (plus pilots)
- Outdoor seated events: 10,000 or 25% (plus pilots)
- Outdoor other events: 4,000 or 50% (plus pilots)

STEP 4

No earlier than 21 June

At least 5 weeks after Step 3

All subject to review

 **EDUCATION**

- As previous step

 **SOCIAL CONTACT**

- No legal limit

 **BUSINESS & ACTIVITIES**

- Remaining businesses, including nightclubs

 **TRAVEL**

- Domestic overnight stays
- International travel

 **EVENTS**

- No legal limit on life events
- Larger events

Surveillance

64. Surveillance is undertaken nationally, regionally, sub-regionally and as data has improved, at local level through our Surveillance and Monitoring workstream. National surveillance is through PHE and JBC (Joint Biosecurity Centre), which monitor for trends and patterns, and any concerning variations. This includes genomic sequencing and surveillance which has resulted in the detection and identification of variant strains. At regional level (London), PHE (LCRC) produces data which is shared routinely with all DsPH and Public Health intelligence teams. SEL CCG produces an early warning dashboard which has helped in the surveillance and monitoring particularly in relation to our NHS

acute providers in SEL. Locally we integrate data from a variety of sources and produce data products as listed in table 3 below.

65. **Waste water surveillance:** The Joint Biosecurity Centre (JBC), working with Thames Water, has been conducting waste water sampling for SARS-CoV-2 at around 30 sites around London since mid-December 2020.
66. Although viral concentrations cannot yet be directly converted into population prevalence, trends over time and comparisons in results between sites can provide insight into the relative levels of COVID-19 circulating in the population. The size of the catchment areas of the sampling sites vary, and this needs to be borne in mind when interpreting results. An example of the outputs is shown in the diagrams in appendices and include:
 1. (In Appendix 2) A graph of daily *SARS-CoV-2 RNA concentrations detected in each sampling sites*. – key considerations include – trend and level of detection. A one-off high reading can be misleading due to sampling problems, but consistent trends in change and when comparing to other areas should alert to higher levels.
 2. (In Appendix 3) A map of change in RNA concentrations and size of catchment area. – the JBC also reports level of detection in a map as well as change in detection. Here – the location of the sampling sites and the size of catchment area can be seen and compared to the graph to understand where the changes are occurring.

Currently there is pilot work to use waste water samples to support surge testing for detection and control of VOC, through genomic sequencing of waste water samples – but this is work in progress, focusing on Bristol.

Data integration and information sharing

67. Data is a critical part of the Pandemic response at every level from national to local. As time has gone by, data has become increasingly granular and sophisticated. During the first wave, data was hard to come by for Directors of Public Health but following the publication of the first iteration of the Contain Framework in the subsequent six months, the quality of data and the platforms for sharing data (Power BI, SharePoint, NHS Digital, Foundry, NIMS) have progressively improved – giving local Public Health teams a better understanding of the Pandemic, where to target, testing data and now Covid vaccination data.
68. With these myriad data sources that are often reporting different values, with different lag periods and different methodologies, it has become one of the important tasks of our Surveillance and Monitoring workstream led by a small team of Public Health intelligence specialists, to unpick the data, triangulate it and present it to local stakeholders in formats that are easier to grasp and make sense of.
69. A particular focus is currently on understanding in depth, the true picture of Covid-19 related health inequalities through the integration and synthesis of quantitative and qualitative data, especially around Covid-19 vaccination. This is to help inform local policy and target the work currently underway on vaccine inequity and hesitancy. It will also help inform future Public Health planning and activity.
70. Our Surveillance and Monitoring Workstream generates the following products:

Table 3: Data Products of the local Surveillance and Monitoring workstream

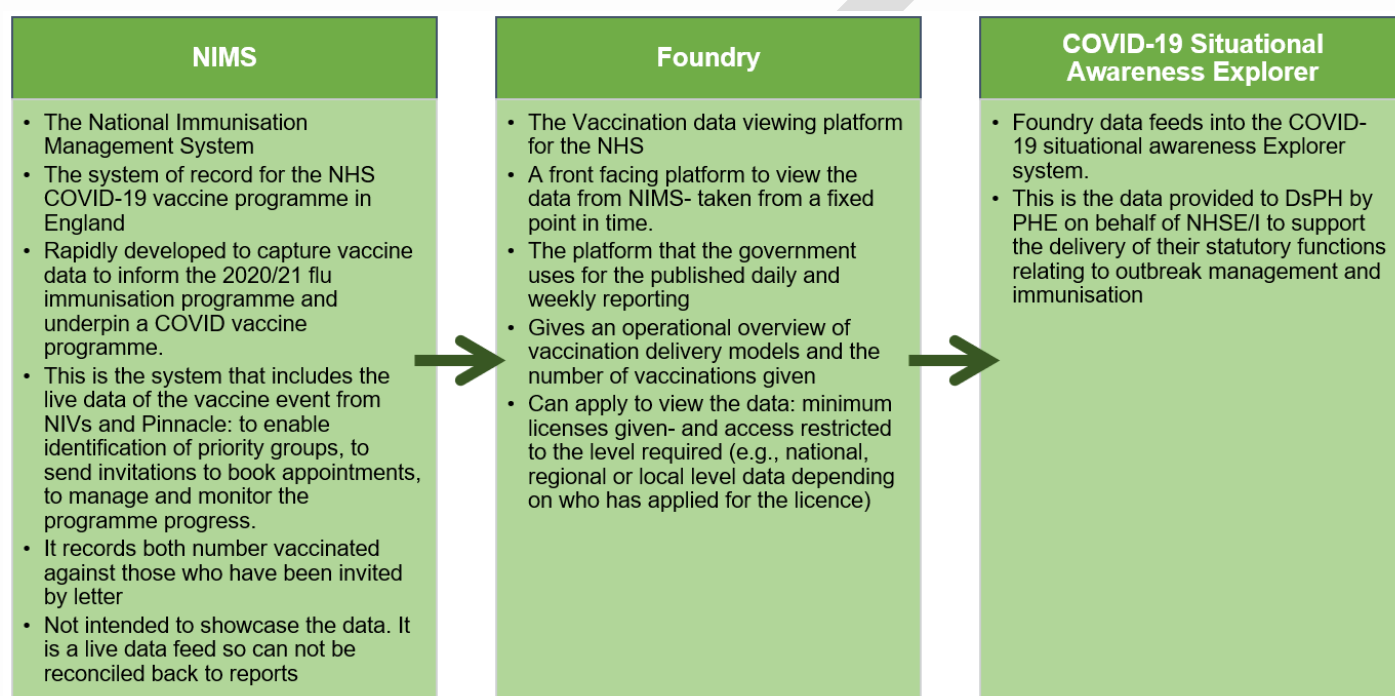
	Product	Frequency	Audience	Information Sources
1	Covid-19 Internal Dashboard	Daily	LBB Gold, Health Protection Board, Elected members	Power BI, NHS Digital, PHE SharePoint, GOV.UK, ONS and Local death data, LG Inform, Acute data, local data reporting
2	Covid-19 Public Facing Dashboard (see paragraph 55)	Daily	On Council website for residents and stakeholders https://www.bexley.gov.uk/coronavirus-covid-19	As above
3	Summary dashboard	Weekly	LBB Gold	As above
4	Testing Dashboard	Weekly	LBB Gold, Testing Working Group	GOV.UK, Power BI, Pillar 2 Regional Dashboard, MTU reports, Local data reporting
5	Covid-19 Vaccination Dashboard (local)	Weekly	LBB Gold, Vaccination Board, Health Protection Board	SEL CCG Vaccination Dashboard, Foundry, NIMS, Power BI
6	Covid-19 Vaccination Health Inequalities and Unwarranted Variation Report (quantitative analysis)	Fortnightly (as new data informs)	LBB Gold, Vaccination Board, Health Protection Board, Outbreak Engagement Board, Comms and Engagement Workstream, Vaccine Hesitancy Task and Finish Group	SEL CCG Vaccination Dashboard, Foundry, NIMS, Power BI, Emis Enterprise
7	Covid-19 Vaccination Health Inequalities Profile (synthesized qualitative and quantitative data)	Ad-hoc (as new data emerges)	LBB Gold, Vaccination Board, Health Protection Board, Outbreak Engagement Board, Comms and Engagement Workstream, Vaccine Hesitancy Task and Finish Group	From #5 and all insight work currently completed

71. Covid-19 vaccination data is collected at vaccination sites and captured through the National Immunisation Vaccination System (NIVS) (hospital sites) and Pinnacle systems (all other sites including GPs). From these systems the data flows into the National immunisation Management Service (NIMS). NIMS is the system of record for the NHS Covid-19 vaccine programme in England that includes the live data of the vaccine event.
72. The data from NIMS can be viewed through Foundry, which is the NHS front facing platform for the data. The government uses Foundry for the published daily and weekly reporting. Applications can be made to view the Foundry dashboard with access to the data limited to the level at which the user requires the data, whether this is local (borough), regional or national level. Local Authority Directors

of Public Health (DsPH) are able to request access for themselves and for two other named individuals. Foundry data also feed into the Covid-19 situational awareness Explorer system, which is shared with DsPH and their teams.

73. Data from NIMS also flow through NHS Digital into the various GP patient record systems, and from there, through into Integrated Care System (ICS) population health management platforms/reporting tools such as Discovery or Healtheintent. In addition to these platforms/tools being available to NHS organisations within each ICS, some local borough teams and DsPH may also have access to these platforms and their analytical outputs (for their respective borough/ICS).
74. The summary of the current vaccination data systems is described below.

Figure 7: Covid-19 Vaccination Data Systems



75. There two key gaps in the data available centrally:
1. Data on ethnicity continues to be patchy even on Power BI, where the data is more complete, for example, for Covid positive individuals than Covid negative ones, and on vaccination data (denominator is not reported hence very difficult to validly compare, analyse and draw conclusions) – this despite the PHE report on the disproportionate impact of COVID-19 in June 2020 highlighting improving reporting of ethnicity data as the first of seven recommendations.
 2. Data on testing done at our Asymptomatic Mass Testing Centre at the Civic Offices lacks demographic information, making it impossible for us to build a picture about who is coming to test, and understand if there are any inequalities or lessons on who to target more or better.

Community testing

76. London testing strategy as with Bexley's own testing strategy aims to detect cases early and prevent onward transmission of Covid-19, facilitate surveillance, investigate and manage outbreaks, and enable the safe reopening of the economy. The overall strategy can be found in Appendix 4.

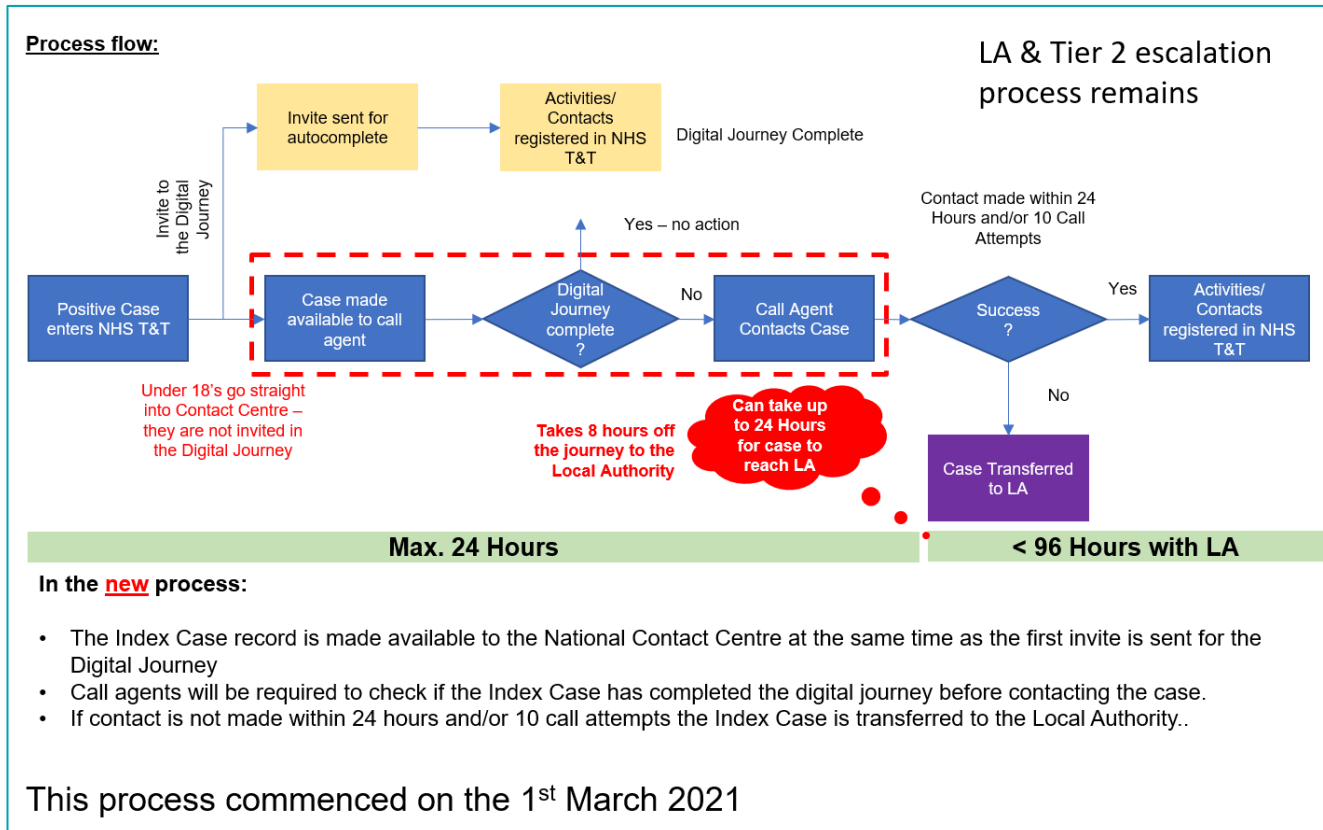
77. During the second wave of the Pandemic new modes and technologies for Covid-19 testing became available. In terms of technologies the latest is the Rapid Testing or LFD (Lateral Flow Device) Testing (also called LFT – Lateral Flow Testing). This technology enables rapid case detection with the results obtained in 30-40 minutes. LFD testing however needs a confirmatory PCR (Polymerase Chain Reaction) test (which remains the gold standard for Covid-19 testing) if done in a non-supervised setting such as at home.
78. In terms of modes of testing, the following are locally available (all fall under Pillar 2 testing):
 1. **Local Testing Sites (LTSs)** – which are symptomatic PCR testing sites. Bexley has four LTSs.
 2. **Mobile Testing Units (MTUs)** – which are usually drive through testing sites, again for symptomatic PCR testing. Bexley has one MTU.
 3. **Asymptomatic (No Symptoms) Mass Testing** – these are rapid LFD testing sites. Bexley has one at our Civic Offices with more under development through a network of community pharmacies and a bus.
 4. **Ad-hoc pop-up MTUs** – which are set up when a specific geographical area needs additional testing capacity if there is a significant increase in the case rate, or a large or complex setting has an outbreak and testing needs to be done quickly, or for variant surge testing. Bexley had two pop-ups at the peak of the second wave.
 5. **Schools testing** – established in all Bexley schools especially since schools opened to all pupils from 8th March '21.
 6. **Home testing** – this is available through the NHS portal or by phoning 119 and is different for symptomatic testing (PCR), and asymptomatic (no symptoms) testing (LFD).
 7. **Workplace testing** – this is offered through individual employers for their workforce and is LFD asymptomatic (no-symptoms) testing.
 8. In addition, both PCR and LFD testing has been going on for some time now in **adult social care settings** such as care homes etc. for staff, residents and visitors.
79. We have developed a Council microsite for testing that lists the local offer on testing (it is regularly reviewed and updated) and for booking to our Mass Testing Site at the Civic Office:
<https://www.bexley.gov.uk/coronavirus-covid-19/services-status/local-covid-testing-centres>
80. DHSC funded and enabled Local Authorities to develop asymptomatic (no symptoms) community mass testing offers in their boroughs to rapidly detect and contain Covid-19. In Bexley our approach targets the following cohorts:
 1. Household contacts to identify further cases and contacts
 2. Workforce at higher risk of exposure in public and private workplaces
 3. Residents in shopping areas/ town centres
81. Our local community mass testing model is being delivered through a Mass Testing Centre at the Bexley Civic Offices with a capacity to test 570 people/day seven days a week, and soon a network of 7 community pharmacies across Bexley (and possibly more to follow) will be delivering rapid LFD testing through our Neighbourhood Rapid Testing programme.
82. As part of the work on vaccine hesitancy we are soon to start a Covid health bus which will deliver targeted mobile rapid testing.
83. Schools have embarked on a nationally stipulated regime of LFD testing which has significantly amplified in magnitude since 8th March '21 when schools fully reopened to all pupils. This includes:

- Providing home testing kits for all secondary and colleges staff, alongside the current provision for primary staff
 - That secondary school/college students should be tested on site via an ATS three times on their return to school/college and then regularly (twice weekly) at home thereafter Schools/colleges will maintain a small on-site testing facility to provide testing for 'at risk' students
 - That testing in schools/colleges should be regularly monitored and that any unexpected data (dips in participation, low positivity rates) are examined and addressed through the Department for Education REACT teams
 - Providing twice weekly home testing for the private nursery workforce
 - No testing for primary school aged children
 - Expanding twice weekly testing to adult learners
 - Providing twice weekly testing for all staff and students on site at universities
 - Expanding testing for children's social care
84. We fully expect that as schools testing is rolled out this will result in an increase in case detection (which is the intended purpose) and that the significant decreases in case rates will slow down or even increase.

Contact tracing and enhanced contact tracing

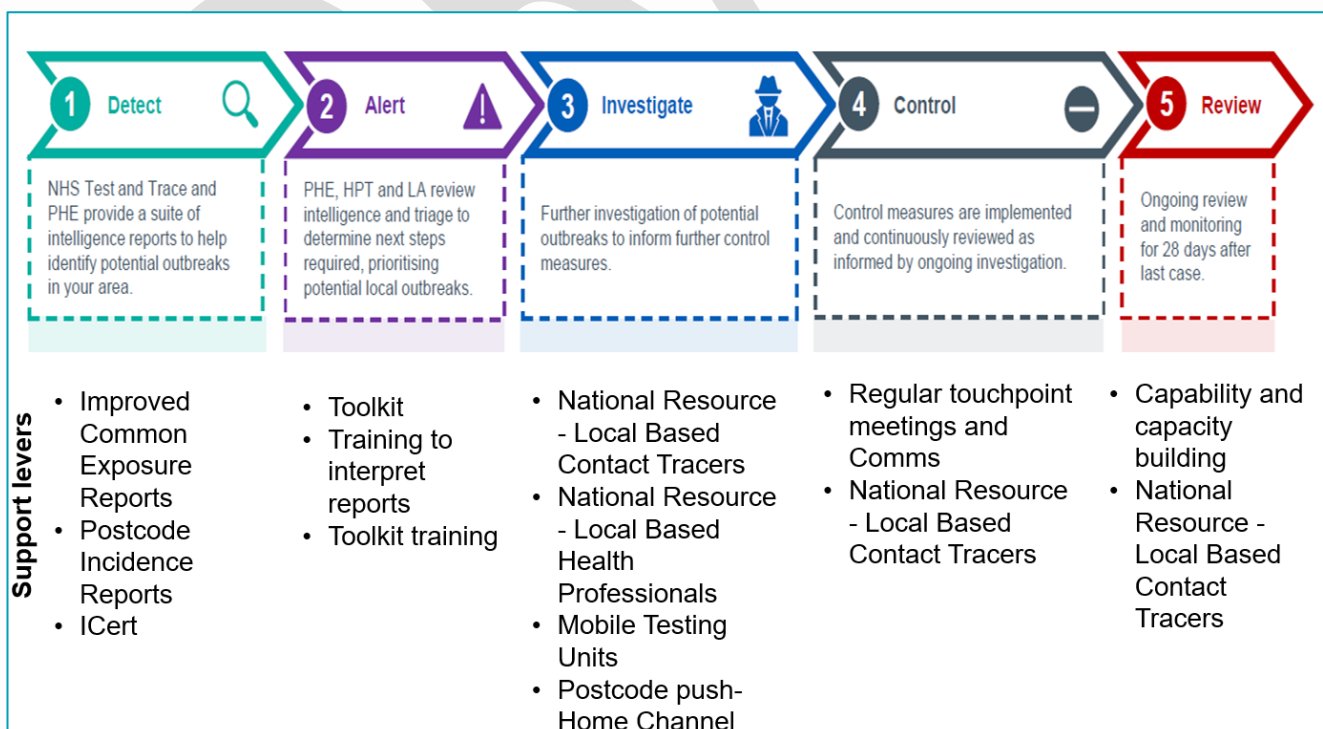
85. Public Health England has had a system of contact tracing predating this Pandemic. This is a critical element of the Pandemic Response and developed further under the NHS Test and Trace Programme into a tiered approach of Tier 1 to 3 operators. Tier 1 being experienced PHE Health Protection experts (in London the LCRC), Tier 2 operators being professionals with previous experience of contact tracing, health protection, Public Health (the retired NHS workforce), and Tier 3 operators comprised of call centre type workforce trained to deliver support and undertake contact tracing based on scripts. Tier 3 forms the largest number of operators across the country.
86. In the latter half of 2020 the opportunity was offered to Local Authorities to set up their own local enhanced contact tracing in partnership with PHE. The Local Authority system receives the contact details of only confirmed cases (not case contacts) from NHS Test and Trace who have not been successfully contacted after 24 hrs since testing positive or after 10 call attempts were made. These cases are then taken up locally and further attempts are made to contact the cases, advise them to self-isolate and identify any further contacts. A schematic of the process flow is depicted below. The data system underpinning this is called CTAS (Contact Tracing Advisory Service).

Figure 8: Process flow between NHS Test and Trace and LA



87. The diagram below depicts the five stages of enhanced contact tracing and bespoke support in relation to specific outbreaks in the local authority area.

Figure 9: Five stages of Enhanced Contact Tracing and Bespoke Support



88. Bexley's Local Enhanced Contact Tracing programme commenced as a pilot for a month from 28th November following which it continued operating till date. In anticipation of a high volume of cases in January, a pool of Tier 2 call handlers was created from redeployed library staff in the Council. This worked well to absorb the pressures in the peak of the second wave especially in January. Below is a summary of the activity and outcomes of our local contact tracing programme.

Table 4: Summary of activity and outcomes of Bexley's Locally Enhanced Contact Tracing Programme (28/11/20-14/02/21)

Total number of cases worked since start – with outcomes		
Total number cases worked	1459 (from 28 Nov 2020 till 19 March 2021 inclusive)	
Cases contacted	906	(62.1%)
A Questionnaires completed	493	(33.9%)
B Refused to answer	231	(15.9%)
C Already answered	71	(5.0%)
D Failed to contact	553	(37.9%)
E Hospital / too ill	57	(4.0%)
F Passed away	6	(0.5%)
G Escalated Care Home cases	14	(1.1%)
H Language issues	8	(0.5%)
I Other	18	(1.2%)

(Please note – Cases contacted includes all groups except Failed to Contact)

89. Overall around 62% of all cases handed to the local contact tracing team were successfully contacted. These are individuals that the central contact tracing system of NHS Test and Trace were unable to contact and therefore were people that were difficult to reach in the first place.
90. What is evident is that locally enhanced contact tracing is very effective and that as the Pandemic winds down and the number of cases reduce significantly, early detection and contact tracing will become ever more critical to containing any future spread and escalation. It is likely to be the very last intervention to be stood down in our Pandemic response which makes the sustainability of the model an important consideration.
91. A borough like Bexley which was allocated the smallest NHS Test and Trace Grant in London and is experiencing major financial challenges, a sub-regional model for enhanced local contact tracing appears to be an option worthy of consideration. Especially as the national lockdown eases and redeployed staff in the pool of trained Tier 2 call handlers return to their day jobs.

Support for self-isolation

92. Self-isolation of people who have coronavirus, or are at high risk of having the virus, is an integral part of the Covid-19 response and will remain so throughout the medium term, alongside ongoing roll-out of vaccination, particularly considering the threat posed by new variants. To achieve this goal, it is essential both to ensure high levels of compliance with self-isolation for people who test positive for coronavirus and their close contacts. We also need to ensure high uptake of testing, both for people with symptoms and for high-risk people in asymptomatic groups.

93. Individuals are expected to self-isolate if they or another household member have symptoms of Covid-19 and are legally obliged to do so if they test positive for Covid-19 or if they are a close contact of someone who has tested positive. Daily contact testing is being piloted as a possible future alternative to self-isolation, but the current legal requirements (based on expert Public Health advice) are for all confirmed contacts, other than those participating in daily contact testing pilots, to self-isolate for the full required period.
94. The main reported barriers to successful self-isolation include:
 - A lack of understanding about self-isolation requirements and the importance of self-isolation.
 - Concerns about financial consequences and employment risks.
 - The practical, social, and emotional consequences of self-isolation, including:
 - a. access to food and other essential supplies
 - b. not being able to carry out caring responsibilities
 - c. practical tasks such as dog walking
 - d. impact on mental health and wellbeing, including loneliness and boredom
95. An effective approach to ensuring high levels of adherence to self-isolation involves the following elements:
 - **Communications** to improve awareness of when people need to self-isolate, how long for, what this involves, its importance in stopping the spread of the virus, the support available and the consequences of breaking the rules.
 - **Practical, social, and emotional support** for those who need it, organised by councils and community groups.
 - **Financial support** for people on low incomes who are unable to work from home and will lose income through self-isolating.
 - **Targeted enforcement** of breaches of the legal requirement to self-isolate, as well as council enforcement against employers who pressure their employees to break self-isolation when they are required to do so.
96. Over the last twelve months, councils have played a pivotal role in working with local communities and civil society to provide support for people who need to self-isolate. 'Practical Support for Self-Isolation' framework has been developed, that builds on this excellent work and is designed to help provide consistent, visible and accessible support for those who need it to self-isolate successfully, while continuing to promote and learn from local innovation and good practice.
97. The framework sets out the types of practical, social and emotional support that people may need to access if they are self-isolating because they or a close contact have tested positive for Covid-19. It sets out the role of NHS Test and Trace in sharing information with councils about people who may need help in accessing support – and the role of councils in assessing people's needs and helping them access support.
98. The government is providing England Councils with £12.9 million funding per month for the next four months (starting in March 2021 and continuing until June 2021), with a review point in May, to help councils meet the costs involved in assessing people's practical support needs and helping them access support. Where councils decide, on an exceptional basis, to provide direct support, they will, as now, need to meet the costs involved from the Contain Outbreak Management Fund or from other sources.

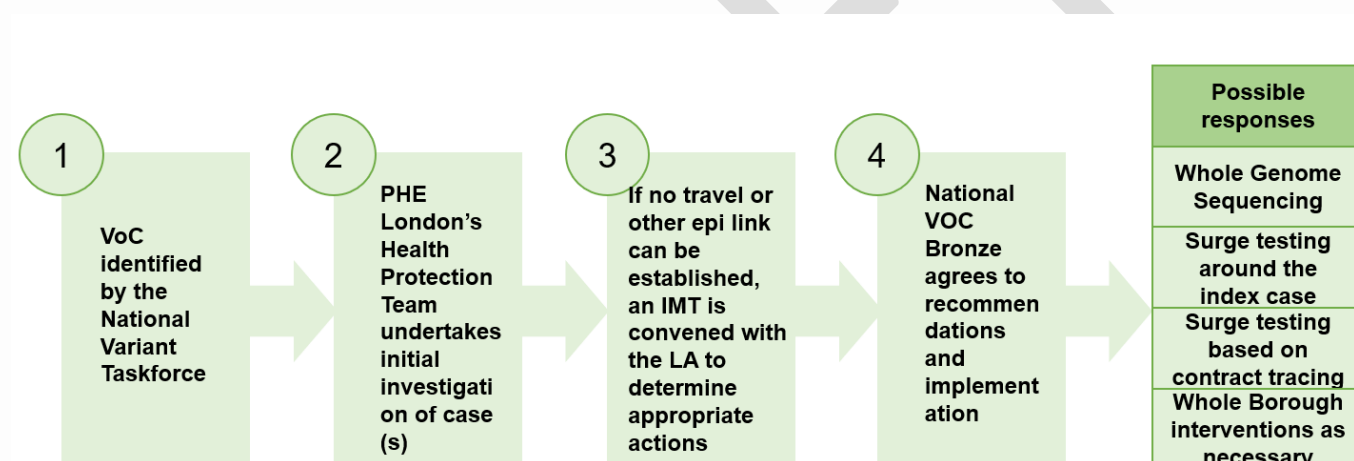
99. The government is extending the Medicines Delivery Service, which currently provides support for clinically extremely vulnerable people, so that it is available to people who are self-isolating and would otherwise be unable to obtain access to essential medicines.
100. As set out in the government's roadmap for easing lockdown restrictions, the Test and Trace Support Payment Scheme will continue into the summer and is being expanded to cover parents who are unable to work because they are caring for a child who is self-isolating. The government is also substantially increasing – to £20 million per month – the funding available to councils to make discretionary payments under the scheme.
101. London Borough of Bexley's Contact Centre team have been making the calls to those needing support for self-isolation and those clinically extremely vulnerable. They are checking what needs those advised to self-isolate require.
102. Bexley Council's experience is that currently there is very little demand for support because supermarkets have sorted their distribution and the period is relatively short (compared to shielding). Where necessary residents are signposted to the voluntary sector organisations that provide a range of support, or in more complex cases referred to social care.
103. The Council website has a great deal of information about the support available from the Council and its partners. If we identify any gaps in our provision our team will provide extra information on the website and identify if additional support is required.
104. In the event the council becomes aware of businesses not supporting self-isolation, this would be escalated to the food safety and trading standards team who would then contact the business. Individual needs would be discussed by the Contact Centre team and addressed as necessary.

Responding to Variants of Concern (VOC)

105. Mutations and variants of the Covid-19 virus can present a significant risk. As well as potentially being more transmissible and leading to more severe clinical consequences for individuals, mutations also present the possibility for Covid-19 variants to more effectively bypass naturally acquired immunity and/or reduce the effectiveness of current vaccines and therapeutics
106. Local Authorities, alongside and with the support of PHE and NHS Test and Trace at regional and national levels, have a key role to play in the investigation, management and control of COVID-19 variants designated as 'Variants of Concern' or VOCs. The overarching purpose is to restrict the widespread growth of VOCs in the population by:
 1. **detecting, tracing and isolating cases to drive down overall community transmission, and**
 2. **case finding additional VOC cases through whole genome sequencing to help assess the risk of community transmission and determine what further interventions and actions are necessary to contain the variant.**
107. With a draft implementation plan in place, London Borough of Bexley is prepared to quickly mobilise a suite of appropriate measures if a VOC is identified in our Borough, including local "surge" testing, and complemented by action to trace contacts and isolate cases as part of a wider strategy to control overall transmission.
108. Following the identification of a VOC, PHE London's Coronavirus Response Cell (LCRC) will conduct the initial investigation to gather additional information, complete a minimum data set and establish whether there are epidemiological links to countries of concern. Those **VOCs without an**

- epidemiological link** will require wider investigation and response, and this will be determined jointly between the Local Authority, on the advice of the DPH, and PHE London's Health Protection Team.
109. The combination, scale and focus of the tools deployed to investigate and control VOCs will be locally led, informed by the data and risk assessment, current epidemiology, knowledge of the local community and grounded in health protection principles and specialist health protection advice. Plans will need to be flexible and adaptable to different circumstances, such as the geography, communities or settings in scope.
 110. The planned local response to a VOC(s) will need to be reviewed and supported by PHE National VOC Bronze to ensure the response is appropriate to the assessed risk and, critically, that the national support required for implementation of the plan (e.g. whole genome sequencing, surge PCR testing) can be mobilised within available national capacity.
 111. The figure below gives a high-level representation of this process, and Appendix 5 describes the measures and interventions that boroughs should consider deploying as part of their local VOC response.

Figure 10: Variants of Concern (VoC) Investigation and Management



Action on enduring transmission

112. Whilst the case rate in Bexley is progressively decreasing as the national lockdown is winding down, with schools and further sectors of the economy opening according to the Prime Ministers' roadmap, there is a risk of case rates rising and with that localised community transmission may once again increase and become embedded.
113. An area with enduring transmission is one where transmission rates have remained stubbornly high and above national and regional averages for long periods of time. DHSC/ JBC needs to do further work to make this definition more precise.
114. There is no single cause for enduring COVID-19 transmission rates - and therefore no silver bullet to resolve them. Instead, it is likely to be due to a range of interconnected factors in each location like deprivation (including unmet financial need), employment and occupation, demographics and household composition, attitudes and behaviours, and the effectiveness of response.

115. Currently there is no area in Bexley or indeed in London with enduring transmission, but it is possible at any point if there is increased community transmission, that there could be localised or hyperlocalised areas emerging in Bexley with such enduring transmission.
116. Stringent surveillance done at national and regional levels by PHE and JBC, along with local surveillance are expected to triangulate and pick up early warning signs of such enduring transmission.
117. Analogous to the steps for surge testing, any local or hyperlocal areas (areas described statistically as Middle Layer Super Output Areas – MSOAs – with mean populations of about 7,000 people) where the data suggests there is enduring transmission, will require rapid risk assessment and detailed location analysis to identify sources of transmission (a known setting/ super-spreader event/ common exposure sites) in order to detect further cases and contain transmission. This will be undertaken through close collaboration between PHE, DHSC and Local Authority.

Ongoing role of Non-Pharmaceutical Interventions (NPIs)

118. With the highly successful and high-profile NHS Covid-19 vaccination programme underway, there is a very high risk of complacency creeping in, with the notion of being protected resulting in people and indeed institutions and settings dropping their guard. It is very important through on-going C&E to reinforce the importance of NPIs and messages like hands-face-space. This is something being actively promoted in Bexley.
119. Social distancing, use of masks in public spaces, appropriate PPE use, hand-washing, ventilation, school closures, travel restrictions, quarantining, supporting people during self-isolation, ensuring compliance and as a last resort using enforcement powers are all part of the family of NPIs. Bexley is currently reviewing compliance and enforcement measures that can be put in place to ensure we create Covid safe environments (see below).
120. A combination of these measures is especially important as the national lockdown eases. It is by establishing multiple layers of protection rather than any single measure alone, that we will continue to reduce the transmission of Covid-19.
121. There are several reasons why NPIs will have an important on-going role:
 1. Firstly, even if an individual is vaccinated it does not confer 100% protection and data is still being assessed on the field efficacy and length of time for which protection is conferred.
 2. Secondly, it is not yet fully established whether vaccination prevents onward transmission, so while an individual is protected through vaccination it may be possible that they are still able to transmit the virus to others.
 3. Until the UK achieves herd immunity, despite the current success of the vaccination programme, the virus could still exist and be transmitted causing localised outbreaks and areas of enduring transmission.
 4. Even if the UK achieves herd immunity at some point, with international travel resuming and with it, tourism, the virus or a different strain of it can be transmitted back into the UK. Such are the interdependencies of modern life, that the entire world needs to have achieved herd immunity before there is a high degree of protection.

5. With the emergence of new strains and the virus constantly mutating, the current vaccinations may not be as effective against a yet unidentified VoC or even the current crop of VoCs. Only NPIs will help protect and mitigate.
122. Along-side NPIs it is very important to maintain the cover of community testing to detect cases rapidly and contact tracing and isolation to kick-in to contain the infection.

Interface with vaccines roll out

123. The NHS Covid-19 Vaccination Programme is quite possibly the most significant Public Health intervention of this century, given that it is the most important tool to help us come out of this once in a century Pandemic. Local Authorities have a key role to play in supporting this programme. Till date Bexley has had one of the highest uptakes among the JCVI priority groups in SE London and indeed London. One of our PCNs (APL) has been recognised as the best performing PCN in the whole country.
124. Appendix 6 describes the overall governance of the vaccine equity work across London.
125. Appendix 7 describes the overarching London approach to tackling vaccine hesitancy and inequalities built upon four pillars.
126. Bexley Council is working seamlessly with NHS counterparts to help facilitate the effective uptake of the vaccination to residents in Bexley with a special focus on inequities and health inequalities, ensuring nobody is left behind. The structures and governance undergirding this have been described in the governance section of this document earlier on.
127. The high level of vaccination up-take indicates an opportunity, and resident's appetite to address the health risk factors that caused them to be at higher risk of Covid-19. We are committed to building on the learning, data and interest in improving health in the borough.
128. The Council role includes facilitating and hosting a Mass Vaccination Centre at our Civic Offices, planning and delivering a mobile vaccination element with NHS Primary Care, articulating and identifying vaccine related inequities, unwarranted variations in uptake and health inequalities in Bexley, and tackling this through direct interventions. These interventions have been outlined in the Communications and Engagement section earlier.
129. From a Comms and Engagement perspective, Bexley Council's role is to support the smooth running of the regional vaccination programme by:
 1. Informing and engaging our wide range of local audiences, some of whom are expected to be resistant to vaccines
 2. Reducing health inequalities by making sure the right people get the right information in a way that is accessible to all
 3. Tackling myths and misinformation in a robust, joined-up and timely way
 4. Building public trust in the safety of the vaccine among our communities and providing facts in a simple way that enable residents to make their own choices in an informed way
 5. Maximise the vaccine uptake in Bexley, using trusted local voices to reassure and provide facts so that people can make an informed choice
130. We have some secondary engagement objectives which support the overarching objectives above:
 1. To identify and engage with Bexley residents unwilling or unsure about vaccination -discovering reasons and sentiments driving resistance/uncertainty

2. To identify demographic gaps where conventional comms is not 'landing' and understand the reasons for this
 3. To establish a number of 'trusted voices' to convey peer-to-peer messages and assist with vaccine uptake within the Community Champions Network as well as other faith and community contacts
 4. To ensure key Public Health messages are received and understood by various communities across Bexley and to build on this to deliver improved Public Health.
131. We are taking a two-pronged approach to engagement:
1. We are seeking to engage the **General Adult Population** in key messages, using:
 - i. Community Champions Network
 - ii. Partner Communications Channels
 - iii. Social Media
 2. We are seeking to engage the following **Targeted Groups** where we know that vaccine hesitancy will have a significant negative impact on health outcomes and community transmission. We will use more bespoke messaging to address foreseen health inequalities issues and misinformation that relates to the following groups:
 - i. Bexley's Health and Social Care Staff (aged 18+)
 - ii. Bexley's Black African Communities (aged 18+)
 - iii. Bexley's Muslim Communities (aged 18+)
 - iv. Bexley's South Asian Community (18+)
132. Our approach to undertaking this work is detailed in Appendix 8. The time-critical and phased nature of the vaccine roll-out means that the following strands of engagement work will all happen in parallel. They are not phased but co-delivered. For example, the insight gathered throughout will inform the tailoring of messages.

Activities to enable 'living with COVID' (COVID secure)

133. Below are the four key epidemiological principles that should guide us through the next phase of exiting the pandemic and living safely with COVID-19:
1. Transmission of the virus needs to be brought, and kept, as low as possible.
 2. Surveillance of transmission and variant emergence must be optimal.
 3. Test, Trace and Isolate needs to work effectively, with a clear testing strategy.
 4. Vaccines must be effective and delivered equitably.
134. These principles are underpinned by what seems now to be an evident reality: the virus and its variants will continue to circulate for some time. Given this, our emphasis must be on creating the conditions and articulating the ways in which we can function and live as safely as possible with the virus continuing to circulate. It can be assumed that even with vaccines, variants of the virus will circulate endemically for some time to come. We will have to find a way of living and working while variants of the virus circulate for at least the next 24 months, if not longer.
135. This needs a well-articulated and thought out strategy that is phased and is led nationally and fine-tuned and implemented at all levels and especially locally.
136. **Phase 1: Exit lockdown and "live with Covid"**
- There are four epidemiology conditions outline above should be met before exiting lockdown. However, these four conditions in and of themselves are not sufficient. Each condition is

complex and needs to be understood as policy problems in order to work effectively. Condition three for example, needs to be broken down further into a system, to which there are dimensions much wider than purely epidemiological. It is arguable that these non-epidemiological considerations have been overlooked.

- The confidence of the public, and all actors in the system, is crucial in any major health protection challenge. A strong psychological contract with citizens is needed to achieve a sustained exit from lockdown. Fostering greater public trust and understanding, providing clear communications, and building social will and solidarity to persevere with these measures is fundamental. Without this, any attempt at re-opening is likely to fail. We need people to understand and support why and how to exit and sustain exit from lockdown.
- Living safely with Covid must be an exercise in building a strong understanding of risk and safety and a strong motivation to play one's part if it is to have any prospect of success.

137. **Phase 2: A well-articulated, careful and gradual "opening up"**

There are several steps which must be taken to begin to "open up" and this must be careful, well modelled, and well planned. We need to enable all sectors of society to be focused on reducing risk. The following steps should be taken:

1. Continue following the four key principles.
 - a. When adjustments are needed locally or nationally, they must be clearly articulated and communicated.
2. Develop as robust an understanding as possible of which sectors of the economy make what level of contribution to transmission and within this seek to:
 - a. Purposively choose those sectors which can be re-opened, articulating very clearly when and how.
 - b. Make re-opening of sectors explicitly dependent on sustaining low transmission.
 - c. Identify very clearly those which cannot yet be re-opened and to articulate very clearly when and how.
 - d. Enforce this.
3. Enable sectors which can re-open to develop, implement, lead, and refine strategies for safe re-opening which they own, building on successful work earlier.
 - a. Create models which work and can build a "plug and play" approach.
 - b. Create models which use the full range of test, trace, isolate.
 - c. Enable wide local enforcement powers for when they fail.
4. Require each sector to build a strong understanding of risk and safety and a strong culture focused on "living and operating safely in a Covid era" as a fundamental condition of re-opening.
5. Underpin this with communications, regulations and enforcement powers built on creating and sustaining an accurate understanding amongst the population of what is safe and what is risky behaviour.

138. **Phase 3: Ongoing monitoring, modelling, surveillance and adjustment**

This phase should be simultaneous with Phase 2 and seen as an iteration and refinement of it.

139. **Phase 4: Continuing improvements in vaccine and treatment**

This phase should also be seen as simultaneous with Phase 2. It should aim to continue working to improve vaccines to resist variants as well as improve treatments to reduce morbidity and mortality.

140. As the national lockdown eases, this is an important area for further development locally and in conjunction with other London boroughs and DsPH.

Resourcing

141. With the first iteration of the national Contain framework in June 2020, the Government announced NHS Test and Trace Funding for local authorities. The allocation was proportionate to the Local Authority Public Health Grant Allocation – in the case of the London Borough of Bexley this put us at considerable disadvantage as we have the lowest per capita allocation of Public Health grant in London.
142. Bexley therefore received the lowest funding in London despite having many care homes, high proportions of older people, a large number of schools and pre-existing lack of investment in Public Health infrastructure including technical capacity. Bexley has had to respond to at least the same, and in fact on average greater challenges than the rest of London (Bexley had the second highest case rate in London at one point) with the least amount of funding in London.
143. The current system in place to address the Pandemic in Bexley is as resilient as it can be given the limitations in funding. However, maintaining future resilience especially with redeployed Council staff returning to their core duties, will be challenging without continued and further funding.
144. PHE studies on disparities in the risk and outcomes of Covid-19¹¹ indicate strong co-relationships with age and sex, deprivation, ethnicity, occupation, inclusion health groups (rough sleepers, homeless, unregistered populations), and underlying health conditions such as obesity, diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia. Most of these factors have contributed to Bexley's high case and death rates. In Bexley for example 66% of adults over 18 years are classed as overweight or obese – significantly higher than London (56%).¹²
145. However, because of close pre-existing partnerships and effective working relationships, support from the NHS, PHE, DHSC, voluntary sector and the goodwill of different agencies, Bexley accounted for itself very well indeed and developed an effective response to the Pandemic.
146. The second iteration of the Contain framework comes with an extra £400m of COMF (Contain Outbreak Management Fund) for Councils in England. This will cover Covid-related Public Health activities during the next financial year. It is hoped that the allocation of this funding will not be based on the Public Health Grant allocation but on a formula that recognises the significant health and funding inequalities in the borough e.g. the Adult Social Care IPC Grant.

¹¹

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

¹² <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/1/gid/1000042/pat/6/par/E12000007/ati/102/are/E09000004/iid/92254/age/1/sex/2/cid/1/tbm/>

147. Lessons learned:

- a. Resource mobilisation needs to start early in the process of establishing local capacity for outbreak control.
- b. Resources should be considered for implementation of the interventions as well as mitigating negative impacts of the outbreak control measures and building community resilience.
- c. While building on existing local capacity and their redeployment, there will be a need to plan for additional capacity to escalate local response if needed and maintain other essential local authority functions and agreed work priorities.
- d. The demand for local interventions is expected to be driven by: number of local cases, size of local outbreaks, need for a baseline minimum function even when the force of the Pandemic dies down, as well as LCRC capacity and demand for mutual aid.

148. Current estimate of additional capacity covers mainly the estimated need for additional Public Health, environmental health and logistics support. Further assessment of additional capacity and financial resources will be undertaken once the COMF allocations are announced.

Risks and mitigations

149. With the evolution of the Pandemic as well as the rules and tools to tackle it, the risks and mitigations have evolved as well. The biggest risk from an epidemiological point of view is the emergence of a new variant strain of the virus that bears one or more of the following characteristics: more transmissible than the current dominant strain (Kent Variant), more harmful in that it causes more morbidity and/or mortality, and lastly that current vaccinations are less effective against it.
150. From a system perspective the biggest risk is the lack of resources or capacity as highlighted in the resource section above. With it, as we move out of the current national Lockdown, staff and resources that were redeployed from other services in the Council will need to resume their business as usual. This can result in a deficit in the resources towards Pandemic response especially for a small team and set-up. Once lock down eases fully and even during transition, there can and will be sporadic incidents and outbreaks occurring which if sufficiently large and sustained can affect business as usual.
151. There are additional risks in terms of as of yet unidentified side effects or adverse effects of any of the vaccines, vaccine supply, vaccine confidence, complacency from vaccination resulting in people dropping their guard especially in observing NPIs.
152. Changes to the current Public Health system nationally can also result in uncertainties, loss of expertise and systems, and confusion about roles and functions.
153. Appendix 9 has a detailed risks and mitigations table.

Conclusions and next steps

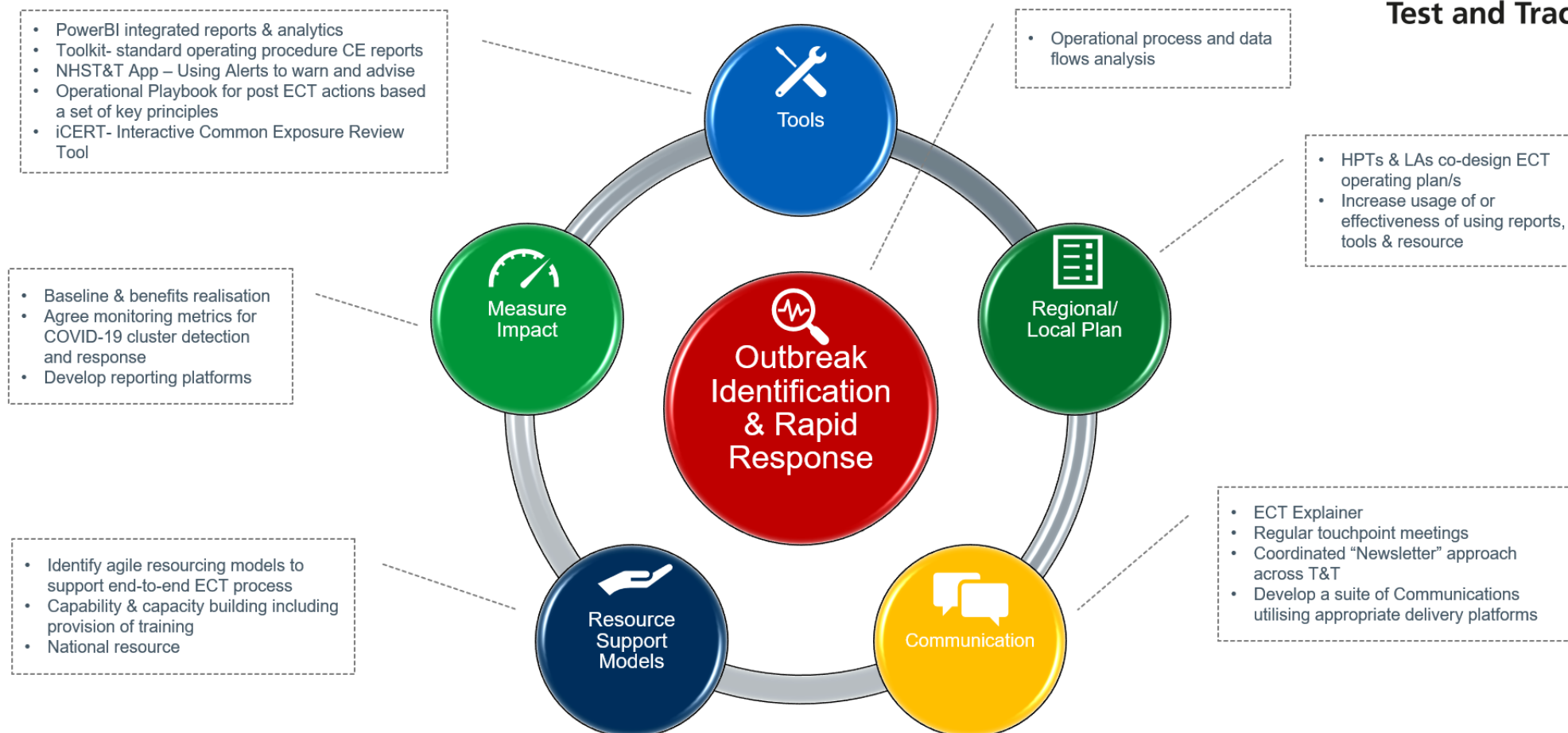
154. As mentioned at the start, this is a draft document that depicts the “plan for a plan”. Many aspects of it are new and were not part of the original Outbreak Control Plan. These parts need further consideration and development.
155. As the Pandemic enters further phases in the months and years ahead, this LOMP may need to be revised again.
156. The final (draft) plan will be signed off by the Health and Wellbeing Board on 22/03/2021.

Appendix 1 : Outbreak Identification and Rapid Response (OIRR) framework

Outbreak Identification & Rapid Response Framework

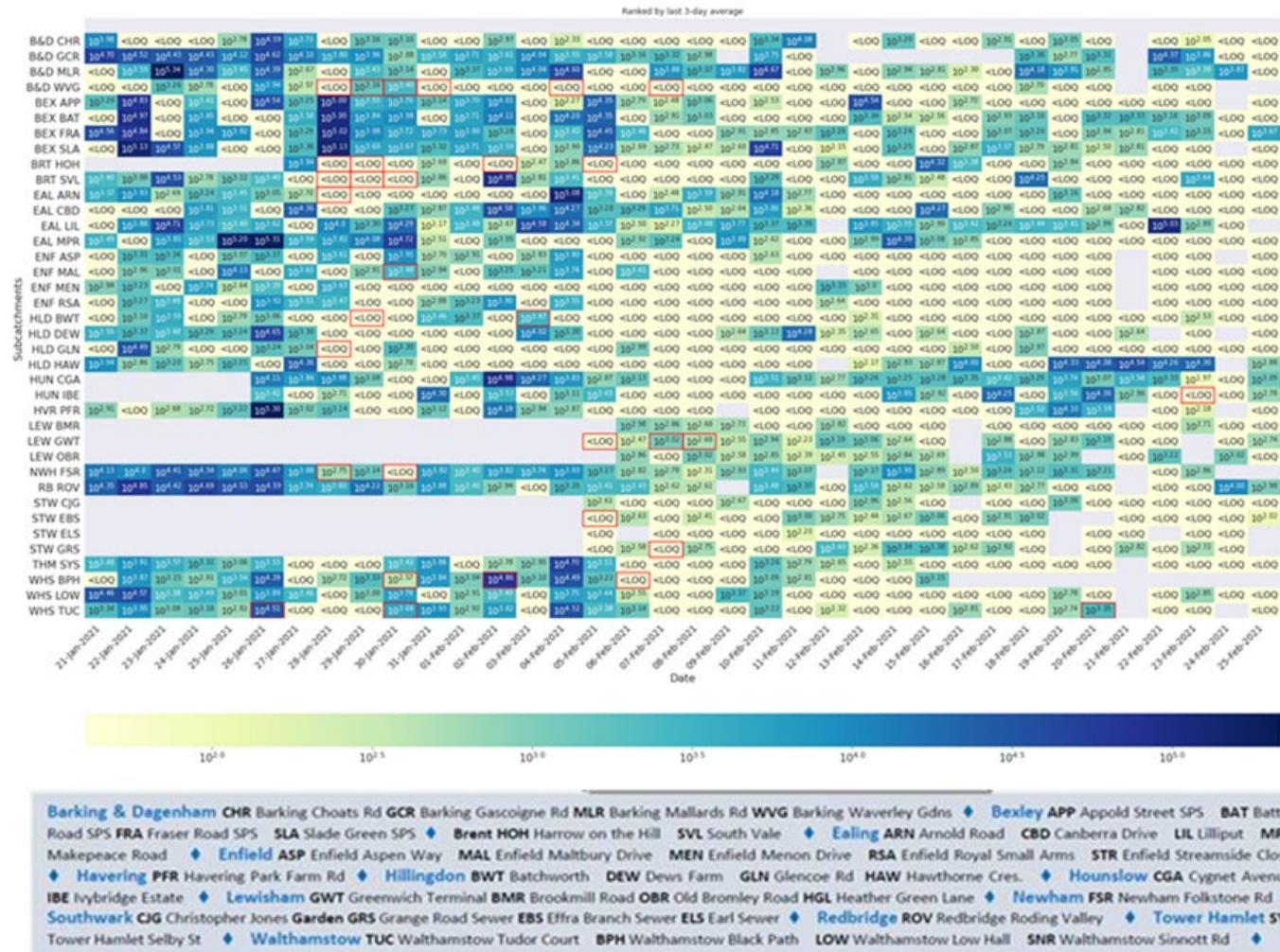


Test and Trace



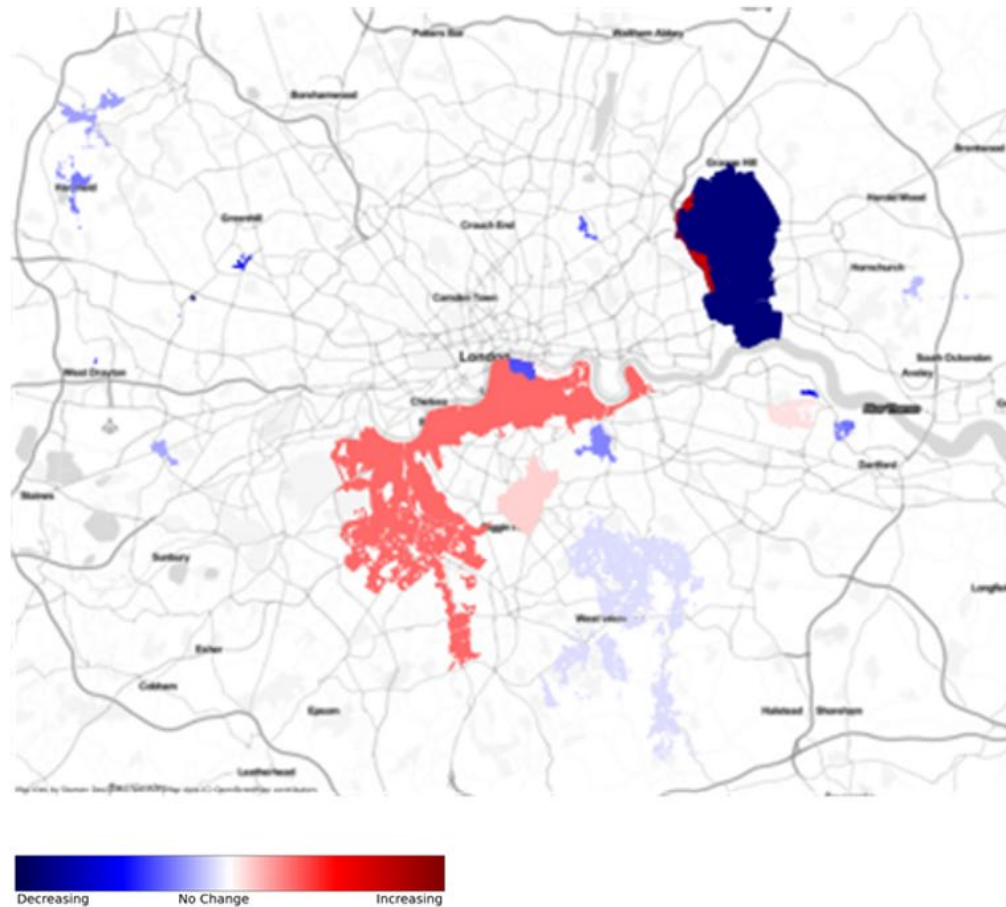
Appendix 2: Waste water Surveillance – daily SARS-CoV-2 sampling

A example of a graph showing of daily SARS-CoV-2 RNA concentrations detected in each sampling sites. Red boxes outline sample estimates that may have been affected by rainwater



Appendix 3: Waste water Surveillance – change in SARS-CoV-2 concentration in London catchment areas

A example map showing the change in SARS-CoV-2 RNA concentration and the size of catchment area



Appendix 4: London Testing Strategy

Aims and Purpose of testing

- To **find** people who have the virus, trace their contacts and ensure both self-isolate to **prevent onward spread**
- **Surveillance**, including identification for vaccine-evasive disease and new strains
- To investigate and **manage** outbreaks
- To **enable** safer re-opening of the economy

Pillar 1 (NHS Settings)

PCR swab testing and LFD antigen testing in PHE and NHS labs (RT-qPCR, LAMP & quicker testing)

- Symptomatic patients that arrive in a hospital setting
- Asymptomatic patients to support infection prevention & control e.g. elective care, inpatient care, mental health, maternity and discharge planning
- Symptomatic NHS frontline staff and in an outbreak situation and household members
- Routine testing of asymptomatic NHS staff and contractors
- Intermittent testing of non-symptomatic NHS staff e.g. as part of SIREN study

Pillar 2 (Mass Population/Community)

Mass symptomatic PCR swab testing (RT-qPCR) and asymptomatic VOC surge testing

- 5 Drive-thru Regional Test Sites
- 28 MTUs and 8 reserves available across London for routine testing and surge capacity deployment
- 86 LTS across 32 Boroughs
- Home Testing Kits
- Regular whole care home asymptomatic testing; weekly for staff, every 4 weeks for residents
- CQC-registered domiciliary care provider weekly staff testing

Pillar 2 (Mass Population/Community) Asymptomatic rapid antigen testing (Lateral Flow Device tests)

- LFD tests delivered through 1,239 asymptomatic testing sites
- New Community Collect programme launches 1 March
- Focus first on parents and bubbles of secondary school children

Other settings:

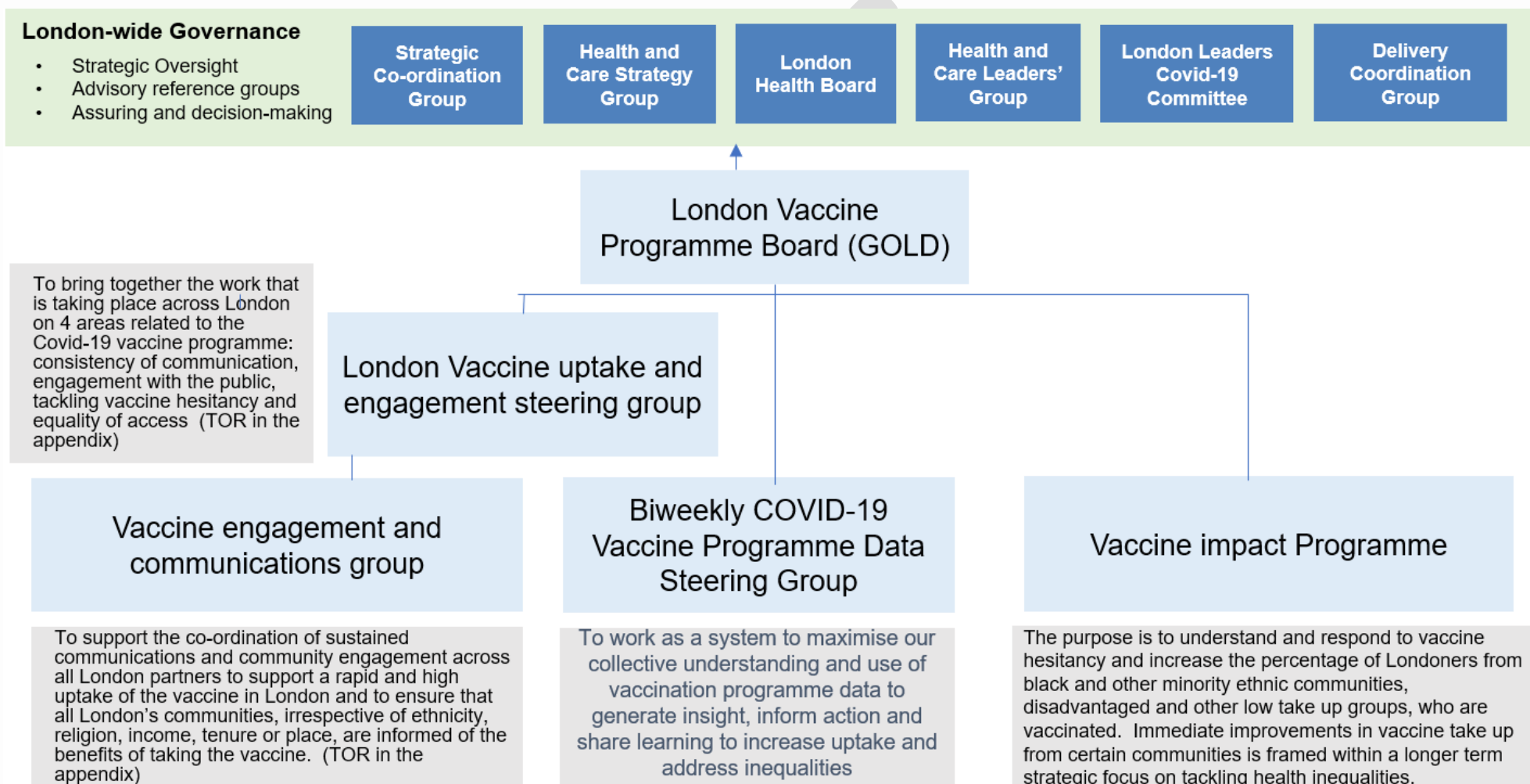
- National pilots/programmes
- Workplaces
- FE students
- NHS staff
- Private sector testing
- Adult social care:
 - Visitors
 - Visiting professionals
 - Rapid outbreak testing
 - Domiciliary care
 - Extra Care and supported living
 - Personal assistants employed by someone who needs care

Appendix 5: Responding to Variants of Concern (VoCs)





Guide to determining Public Health Action- range of approaches

Whole Genome Sequencing	Increase symptomatic PCR testing	Targeted surge asymptomatic PCR testing	Rapid and enhanced contact tracing	Support for isolation	NPIs
<ul style="list-style-type: none"> Define and agree coverage/scope of PCR positives for WGS (over & above routine 5% surveillance) including pillar 1, and time period Data led eg small area/geography around VOC case; setting specific; whole borough Contingent on national capacity Explore leveraging local hospital and academic sequencing capabilities 	<ul style="list-style-type: none"> Consider increasing symptomatic testing capacity via additional MTU deployment, increased or changed opening hours Enhanced or increased local communications to encourage and ensure people get tested. Start or potentially increase the local booking arrangements for LTS sites 	<ul style="list-style-type: none"> Determine target population, geography or setting Determine best operational method(s) for targeted surge testing eg: <ul style="list-style-type: none"> Door drop model (Council, VCS or other trusted delivery partner, commercial partner) Collect and drop model, roving model ATS (swapping in PCR for LFDs or including supplementary PCR tests for positives) Surge of up to 5000 asymptomatic tests MTUs deployed for asymptomatic testing, not on the national portal, for walk up and booked via local system 	<ul style="list-style-type: none"> Immediate tracing response to positive cases from the defined area/population ie tracing begins on entry of positive case to CTAS/the trace process A dedicated team within NHS Trace contacts all positive cases from the defined area, using tailored scripting LA's Local CT Partnership service works alongside national VOC Trace cell Re-enforcement of isolation and public health advice to all cases and contacts Consider using enhanced contact tracing to identify and investigate potential transmission events/clusters as part of wider OB control 	<ul style="list-style-type: none"> Package of self-isolation support to meet practical and emotional/well-being support needs of cases and contacts Self isolation payments and discretionary support for those in financial need Consider enhanced welfare support/follow up calls and other enhancements 	<ul style="list-style-type: none"> Post national restrictions/lockdown, consider need for targeted, local NPIs/restrictions as part of VOC control approach Reinforce covid-secure and IPC measures in key settings
Communications and engagement					
<ul style="list-style-type: none"> Locally led plan for culturally competent communications and community engagement Coordination of announcements and clear messages about purpose and restrictions in place during implementation of local variant control measures/surge activities Ensure alignment of national comms with local comms Managing the need to inform the public about VOCs without driving negative behavioural or psycho-social outcomes Harness existing community assets, networks and trusted messengers eg community champions Specific considerations include: an inbound helpline; a postcode checker on Council website 					

Appendix 6: Governance of COVID-19 Vaccine Equity work across London



Appendix 7: Four pillars of the London approach to tackling vaccine hesitancy and inequalities

Aspect	Data and evidence 	Addressing hesitancy 	Practical aspects of vaccination 	Monitoring, evaluation and system leadership 
Issues to consider	<ul style="list-style-type: none"> • Data: Best use of available data to understand where the inequalities are, to support local and pan London action and interventions • Evidence: work is rooted in the evidence including behavioural science and from other vaccination programmes. • Lessons learnt: identifying and sharing good practice from other countries, regions, boroughs 	<ul style="list-style-type: none"> • Hesitancy higher in: Under 25 year olds, BAME groups (partic black ethnic groups) & less affluent Londoners • Health and care professionals: Current rates are lower comparatively • Culturally competent community engagement: essential, locally led, regionally enabled • Behavioural insights: understanding models of vaccination behaviours, including role of stigma 	<p>Other aspects affecting vaccination uptake of minority groups</p> <ul style="list-style-type: none"> • Accessibility/familiarity of the setting • Invitation & appointment booking process • Vaccine site location • Opening hours/time off work • 58% of those in the UK answered no to the question 'is it easy to get a vaccine' (Global Institute of Innovation) 	<ul style="list-style-type: none"> • Evaluation: systematic, academically rigorous service evaluation that is agile, answers the essential q's and feeds learning back into the system • Measures of success: clearly defined • System Leadership: join up and oversight across the system, across the <i>test-trace-isolate-vaccinate</i> journey and tackling inequalities from COVID more generally • Potential for drop off for second vaccine: as seen in other vaccines
Next steps	<ul style="list-style-type: none"> • Data: Track and share data on vaccine hesitancy/acceptance, and vaccine uptake (rolling equity audit) • Integrate: Integrate vaccination data with surveillance and T&T data, to inform outbreak control /response • Insights: Facilitate the collection and sharing of insights from across London • Evidence: Synthesise the evidence on barriers, enablers and what works • Quality assure: provide PH input/ advice to ensure communications/ interventions are grounded in evidence • Agile system: Ongoing gathering of evidence / learning from the system 	<ul style="list-style-type: none"> • Coordinated and targeted programmes: reaching specific communities. Current focus on BAME, health and care professionals and inclusion health • Sharing resources and assets: maintain an easy access repository of local, regional and national resources that are sensitive to local communities • Network and support London partners: across organisations to make connections, support workstreams • Develop a bureau of professional speakers • Consider other models: MECC 	<ul style="list-style-type: none"> • Adapting programme delivery: understand barriers to access for minority and vulnerable populations, and feed into and refine NHS programme delivery • Training: emphasise and support healthcare staff in their role as a trusted source of health information for key population groups • Impact of vaccination on behaviours: monitor impact of vaccination rollout on social distancing and adherence to other NPIs; develop clear communications and other strategies 	<ul style="list-style-type: none"> • Evaluation: evaluation of local/STP interventions/approaches, with academic support • Listen and learn: Use range of fora and networks to engage, listen and share good practice and understand partners' support needs • Horizon scan/plan ahead: for groups likely to have low uptake, thinking also of messaging for second vaccine • Celebrate success: keep momentum & promote further action • Extending success: use these opportunities/relationships for wider programmes to reduce inequalities more generally

Appendix 8: Bexley's Covid-19 Vaccine Engagement Approach

STRAND 1: INSIGHT GATHERING

Gathering insight to inform local action.

- Using data and feedback already gathered from Healthwatch Bexley's survey and Community Champions' feedback.
- Feeding in insight from community champions.
- Undertaking a survey of all Community Champions to gather demographic details and collect opinions on vaccination.
- Capturing the insight from Health and Social Care cohort who are more representative of broader population than other people who are currently eligible for vaccine (i.e. younger and more ethnically diverse).

STRAND 2: TAILORING & ADAPTING MESSAGES

- Using a values-based approach to community engagement and assisting the communications strategy by suggesting values-based messaging to certain key demographics.
- Gathering testimonies in 'authentic voices' from different sectors of the community, working with community leaders on different forms of messaging in order to reach residents where traditional comms is less effective.
- Recommend behaviour change techniques to Health Protection Board – to be employed to work with values insight.
- Celebrating vaccine programme milestones may play a key part in messaging.

STRAND 3: NETWORK BUILDING – Breadth and Depth

- Taking a targeted approach to engaging with less represented groups with the existing Community Champions.
- Growing the community champions scheme from 400 – 500 by April.
- Key community contacts who are signed up to share vaccination messaging within their community.
 - Number of Key Contacts
 - Reach
 - Engagement in Webinars / Activity
- Working with partners to ascertain the 'bigger picture' to provide context – these include colleagues from Royal Borough of Greenwich (RBG), Peabody, Bexley and wider SE London CCGs and other Community Champions network co-ordinators from across England.

STAGE 4: 'LANDING' THE OUTCOMES

This is about using insight, community action and peer to peer communications to change the way that we are working, or the way communities access the vaccine - to 'make it happen'.

- Changing Policy and Practice
- Cascading Messages
- Facilitating the Uptake of the Vaccine – removing barriers and finding solutions.

Appendix 9: Risks and Mitigations

Risk	Mitigation
1.0 Epidemiological	
1.1 Emergence of a new variant that is either or all of the following: <ul style="list-style-type: none"> • More transmissible than the current dominant strain (Kent Variant) • More harmful: it causes more morbidity and/or mortality • Current vaccinations are less effective against it 	Rapid detection, surge testing, self-isolation and containment, with parallel intensive communications and engagement with residents and all relevant stakeholders.
1.2 Escalation in cases in known population groups – especially secondary school children and their families	Early warning surveillance and monitoring system including use of waste-water sampling, Local Zero contact tracing programme, rapid instigation of IMTs and managing outbreaks or situations, engaging schools and residents and effective communications
2.0 Systemic	
2.1 Limited resources and public health infrastructure, and BAU being compromised in case of an escalation in the Pandemic	Building a proportionate Pandemic response framework locally that taps into all sub-regional, regional, and national resources from NHS, PHE/UKHSA, DHSC, JBC, DfE etc. , that is targeted, and intelligence driven Developing system resilience by maintaining a shadow trained workforce from the erstwhile redeployed staff, that can be stepped up when required Plugging into mutual aid resources if required
3.0 Operational	

3.1	Community Mass Testing demand reduces or conversely exceeds capacity	Careful balancing of the resources, testing booths, booking slots, operating hours, and supply of testing (Asymptomatic LFD Testing) with demand on a weekly basis Maintaining the capacity to flex with demand
3.2	Clinical and quality assurance in testing sites run by Bexley Council	Use of SOPs with regular review Reporting of incidents and escalation processes Regular review of testing data and outcomes as part of quality assurance Training and supervision of staff
3.3	Contact tracing service demand exceeds capacity once Local Zero programme is in place	Additional pool of library staff trained and already on the system, on standby whilst in BAU should the need arise Refer cases back to national Test and Trace
3.4	Cross borough cluster of Covid-19 cases	SEL IMT held weekly & London PHE/DPH weekly update to pick up any cross border/London wide issues
3.5	Low vaccination uptake in higher risk communities leading to further inequalities and outbreaks	Extensive engagement with communities to maximise vaccination uptake Implementation of vaccine confidence building programme and comms and engagement plans
4.0	Strategic	
4.1	Negative impacts of outbreak control measures and potential for widening inequalities	Health Inequalities impact assessments – on vaccine uptake Programme of work to tackle health inequalities in Bexley
4.2	Various types of information overload and compliance fatigue – on testing, NPIs, vaccination, self-isolation etc.	Engagement through community champions and community leaders Changing the messages and channels Avoiding information bombardment

Measures to support residents through social prescribing, self-isolation support
Celebrate success and bring back the “fun” element to living with Covid – what you can do rather than what you cannot

5.0 Finance

5.1 Ongoing financial risk to Bexley Council without sufficient medium term funding commitment

Forecast cost of response
Ensure claims made for any additional expenditure incurred and make use of pilot opportunities
Ability to scale back and up as necessary to prevent incurring unnecessary costs