AGENDA

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

Tuesday, 28th July, 2020, at 3.00 pm

Ask for: **Jade Hannah on 01634 332008 or jade.hannah@medway.gov.uk or Ann Hunter on 03000 416287**

Civic Suite, Level 2, Medway Council, Gun Wharf, Dock Road, Chatham, ME14 4TR

Tea/Coffee will be available 15 minutes before the start of the meeting in the meeting room

Membership

Mrs C Bell (Chairman), Cllr David Brake (Vice-Chairman), Cllr A Jarrett, Dr J Allingham, Mr I Ayres, Dr B Bowes, Mr P B Carter, CBE, Mrs S Chandler, Cllr Doe, Mr M Dunkley CBE, Mr R W Gough, P Graham, Cllr Mrs A Harrison, Cllr Mrs J Hollingsbee, Mrs E Lyons-Backhouse, Mr C McKenzie, Cllr M Potter, Mr M Scott, Mr A Scott-Clark, Ms C Selkirk, Mr R Smith, Dr R Stewart, Mr I Sutherland and Mr J Williams

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

1. Agenda Pack for meeting on 28 July 2020 (Pages 1 - 120)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Monday, 20 July 2020

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Kent and Medway Joint Health and Wellbeing Board

Notice of a Meeting, to be held as a **Virtual Meeting** in accordance with Regulation 5 of The Local Authorities and Police and Crime Panels (Coronavirus) (Flexibility of Local Authority and Police and Crime Panel Meetings) (England and Wales) Regulations 2020

A meeting of the committee will be held on:

Date: Tuesday, 28 July 2020

Time: 3.00pm

Venue: Virtual Meeting

Membership: As detailed in agenda item 7

Agenda

1 Election of Chairman

To elect a Chairman for the current municipal year.

2 Election of Vice-Chairman

To elect a Vice-Chairman for the current municipal year.

3 Apologies for absence

4 Record of Meeting **(Pages 5 - 10)**

To approve the record of the meeting held on 25 June 2019.

5 Declaration of Disclosable Pecuniary Interests and other interests

Members are invited to declare the existence and nautre of any interests in relation to any agenda item in accordance with the relevant Council's Code of Conduct.

6 Urgent matters by reason of special circumstances

The Chairman will announce any late items which do not appear on the main agenda but which he/she has agreed should be considered by reason of special circumstances to be specified in the report.

7 Kent and Medway Joint Health and Wellbeing Board: Membership **(Pages 11 - 24)**

This report sets out the current position on the membership of the Kent and Medway Joint Health and Wellbeing Board (Joint Board). The report asks the Joint Board to consider appointing additional voting and non-voting Members as recommended by each respective Health and Wellbeing Board on 18 February 2020 and 26 February 2020.

The report also asks the Joint Board to consider appointing non-voting Members as recommended by the Kent and Medway STP Non-Executive Oversight Group in response to changes in the health landscape across Kent and Medway; by Members at the pre-agenda meeting held on 3 June 2020 to ensure continuity as changes in the health system embed and by Members at the Development Session in September 2019 in recognition of the importance in strengthening relationships and engagement between Councils at all levels.

8 Covid-19 Local Outbreak Control Plan Briefing **(Pages 25 - 114)**

This report provides an overview of the response and recovery strategy to protect Kent and Medway's populations from COVID-19 impacts. It describes actions that Kent County Council (KCC) and Medway Council (MC), in partnership with key stakeholders, have taken to develop the COVID-19 Local Outbreak Control Plan (LOP).

The report also sets out the governance arrangements and framework, through which KCC and MC will collaborate to deliver their statutory functions to protect their populations and reduce the spread of COVID-19.

9 Work Programme **(Pages 115 - 120)**

The report advises the Joint Board of the forward work programme for discussion in the light of latest priorities, issues and circumstances. It gives the Joint Board an opportunity to shape and direct the Joint Board's activities.

For further information please contact Jade Hannah, Democratic Services Officer on Telephone: 01634 332008 or Email: jade.hannah@medway.gov.uk

Date: 20 July 2020

Information about this virtual meeting

Please note that any member of the press and public may follow proceedings at this 'virtual' meeting via a weblink which will be publicised on the Council's website ahead of the meeting. Please refer to this meeting via the meeting calendar for further details:

https://democracy.medway.gov.uk/mgCalendarMonthView.aspx?GL=1&bcr=1

Members of the press and public may tweet, blog etc. during the live broadcast as they would be able to during a regular Committee meeting.

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KENT COUNTY COUNCIL

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

MINUTES of a meeting of the Kent and Medway Joint Health and Wellbeing Board held in the Darent Room, Sessions House, County Hall, Maidstone on Tuesday, 25 June 2019.

PRESENT: Mrs C Bell, Cllr David Brake, Dr B Bowes, Mr P B Carter, CBE, Scott Elliott, Cllr Doe, Mr G Douglas, Mr M Dunkley CBE, Mr R W Gough, Mr S Inett (Substitute for P Graham), Cllr A Jarrett, E Lyons-Backhouse, Mr Chris McKenzie, Mr P J Oakford, Cllr M Potter, Mr M Scott, Mr A Scott-Clark, Ms C Selkirk, Ms P Southern and Mr J Williams

ALSO PRESENT: Cathy Bellman

IN ATTENDANCE: Ms K Cook (Commissioning Manager, SCHW) and Mrs A Taylor (Scrutiny Research Officer)

UNRESTRICTED ITEMS

1. Apologies and Substitutes
(Item 1)

1. The Kent and Medway Joint Health and Wellbeing Board agreed that Mr Oakford would be Chairman and Cllr Brake Vice-Chairman for the coming year.

2. Apologies had been received from Dr Allingham, Mr Ayres, Dr Stewart and Mr Sutherland.

2. Declarations of Interest by Members in items on the agenda for this meeting
(Item 2)

1. Cllr Martin Potter made a declaration of non-pecuniary interest as he was a member of the Kent and Medway STP Non-Executive Director Oversight Group.

3. Minutes of Meeting held on 19 March 2019
(Item 3)

RESOLVED that the minutes of the meeting held on 19 March 2019 were a correct record and that they be signed by the Chairman.

4. Progress on Prevention Strategy for Kent and Medway
(Item 4)

Physical Activity Deep Dive

1. James Williams, Director of Public Health for Medway Council, introduced this item, the cost, to the wider economy, of physical inactivity was £7.4billion per year, and to the NHS it was approximately £1.2billion, to Kent it was £18million and Medway £19million, this was a significant burden. The paper set out the actions taken within the system, to address this challenge and asked what more could be done to improve the accessibility and uptake of services.

2. Scott Elliott, Head of Health and Wellbeing Services, Medway Council, explained that the report was based on the principles set out in 'Everybody active every day'. Mr Elliott referred to page 22 of the document - 'Active Society – creating a social movement' and was about raising the profile of physical activity and the opportunities which existed. The second area was 'Moving professionals' Making Every Contact Count and ensuring that physical activity became embedded in mandatory training and conversations relating to physical and mental health and wellbeing. Mr Elliott also referred to Active Environments – creating the right spaces and Moving at Scale – scaling up interactions that make us active.

3. Andrew Scott-Clark explained that the Chief Medical Officer had commissioned a review of the evidence base of physical activity. Although this was not yet published there was not expected to be a major overhaul of the guidelines.

4. Eunice Lyons-Backhouse asked whether "The Daily Mile" was routinely part of the curriculum in primary schools and whether it was taking place in most primary schools. Scott Elliott explained that in Medway around 1/3 of schools were taking part and schools were being actively encouraged to participate.

5. Clair Bell asked about the role of the district councils and their role in looking after open spaces and cycle paths, James Williams confirmed that it was a county sports partnership that worked across Kent and Medway.

6. James Williams referred to people with a disability who were 50% less likely to be physically active.

7. Members commented that finding funding to meet obligations for statutory needs was often difficult, whether this was through the NHS or jointly or locally. It was considered that funding was unsystematic.

Learning Disability Annual Health Checks

8. Allison Duggal explained that people with learning disabilities had poorer health outcomes than the rest of the population. The Learning Disability Annual Health Check (delivered by GPs through a directly enhanced service commissioned by the NHS) was one of the ways in which this was addressed. Around 25% of people with a learning disability in Kent were on the register and of those that were on the register many still did not get their annual health check. There was also sometimes confusion between the Learning Disability Health Check and the NHS health check. The Health Check aimed to provide holistic support and intervention to improve health outcomes. Across Kent there were around 24,000 people with learning disabilities who were not on the register, the uptake was better in more deprived areas. NHS England had set a target for GPs and Clinical Commissioning Groups to increase access to the Learning Disability Health Checks and the NHS Long Term Plan committed to piloting a specific health check for

people with autism. Members of the Board were asked to discuss how partner organisations could support in the areas set out in paragraph 3.5.1 of the report (page 39).

9. Steve Inett asked of those on the register how many were in supported accommodation for example who might be being supported to access the health check? And for those who were not on the register how they were being encouraged to access the health check. Allison Duggal explained that promotion of the learning disability health check experience showed it relied on clinical leadership and pushing forward the health check, this was being looked at currently. Penny Southern explained that in terms of the individuals on the register it was possible to make reasonable adjustments and link to GP surgeries, this was not mandatory and it was a complex picture. There was a wider population who were not accessing the service.

10. Chris McKenzie commented that it was important to ensure that individuals were on the register and try to ensure that the uptake of health checks was promoted at every available opportunity. James Williams agreed that the board had an opportunity to review what was currently happening and possibly undertaking a deeper dive with engagement from colleagues in primary care. Penny Southern agreed that it would be helpful to have a further look at this issue including alternative ways of delivery. Bob Bowes explained that as this was voluntary there was a degree of choice and some GPs may not understand the benefit that health checks bring to the resident.

11. Angela Harrison asked whether it would be possible to have the numbers/percentages on individuals on the register for each district? The Chairman suggested that this be followed up outside of the Board meeting.

12. Bob Bowes suggested that the Board recommend to Commissioners that they wished to see an improvement in the take up of Learning Disability Health Checks. The Chairman challenged the NHS Board Members to have a further look at this and bring a paper back to a future meeting.

RESOLVED that Members of the Kent and Medway Joint Heath and Wellbeing Board challenge the NHS Board Members to have a further look at ways of increasing the uptake of Learning Disability Annual Health Checks and bring a paper back to a future meeting.

NHS Check: Over 75 Eligibility

13. Andrew Scott-Clark explained that this paper had come back to the Board following a query about why the NHS Health Checks Program stopped at 74. The paper clarified the basis for the NHS Health Check Program and described the arrangements in place for people over the age of 75. He confirmed that anybody who is registered with a GP (if they haven't been seen within the preceding 12 months) can receive a health check.

14. Cllr Howard Doe queried how many people knew that this option was available? There were concerns that people were not aware and local authorities should do more to make people aware that checks were available and recommend that they take up this opportunity.

15. Cllr Potter explained that he had previously discussed the take up of Health Checks with different cohorts, he asked for a report to a future Board setting out the take up for different cohorts.

16. Dr Bob Bowes asked what the efficacy was and what was the service trying to achieve through these health checks. Cllr Howard Doe agreed and stated that it was important that individuals were aware that this service existed, particularly for people suffering from social isolation.

17. Allison Duggal explained that it was important to consider whether there was a good economic argument for health checks for younger people.

18. Scott Elliott concurred that much of the discussion was around health economics, the data for health checks was important to tackle the health inequalities that exist. The purpose of the health checks was early detection and signposting people to the right services. There was a rich data set which could be shared with Members before the next Board meeting.

19. David Brake asked how any greater awareness would be undertaken? There was a shortfall of GPs in communities, how would this be dealt with? Dr Bob Bowes confirmed that GPs did not always undertake health checks, these were done by a health care assistant and there was no shortage of health care assistants.

5. Progress on Local Care including the Local Care Implementation Board

(Item 5)

1. Cathy Bellman gave Members an update on local care delivery. A copy of this presentation is available here: Local Care Update

2. Cllr Allan Jarrett explained that he had concerns about consistency and approach it was important to ensure that consistency was achieved as quickly as possible.

3. Steve Inett thanked Cathy for being a consistent driving force behind these issues, in response to a question Cathy explained that the ambitions around the investment and numbers achievable were overstated, some sense checking had now been done and the numbers were a lot more realistic.

4. Caroline Selkirk stated that there were two sides to this, in East Kent they looked at the total opportunity rather than what could be achieved in one individual year.

5. Chris McKenzie welcomed the Multi-Disciplinary Teams (MDT) approach, there were significant potential benefits.

6. David Brake highlighted the role of the carers who were relied on so much for help and assistance, including the role of young carers. There was a need to look carefully to ensure that young people where supported as much as possible.

RESOLVED that the Kent and Medway Joint Health and Wellbeing Board note the content of this report, in particular:

a) Support having a framework to assist the development of the MDT/PCNs
b) Endorse the approach to achieving consistency in the delivery of Local Care across K&M; cohort modelling, reporting on inputs/outputs (delivery and financial savings).

6. Update on Kent and Medway Strategic Commissioner and Engagement with Upper Tier Authorities

(Item 6)

1. Dr Bob Bowes gave Members a presentation on Creating a new commissioning landscape in Kent and Medway. A copy of this presentation is available here: Creating a new commissioning landscape in Kent and Medway

2. Cllr Alan Jarrett stated that the more difficult element was allocation of resources, there were difficult discussions had around dealing with conflicting demands and the relative levels of health inequalities and disadvantage.

3. Matthew Scott was pleased to see the continued reference to mental health, in response to a question Dr Bowes explained that the 80% within the presentation referred to the running cost of administration. It was not considered that the NHS was over managed.

4. Steve Inett explained that in the past he had seen the following steps repeat themselves; the award of a contract, the existing provider diminish as the end of the contract approaches, new provider, demand found to be higher than was commissioned for, trimming process – leading to adjusting KPIs or more investment. He asked whether it would be helpful to hold a workshop to look at some examples of what had happened previously and how that would look in the new way. Dr Bowes did not think that the risk of re-procurement was necessarily the area to focus on, it was important to focus on the risk of maturity and confidence that the partners had in each other and the skills with which the commissioners could write the contract. Glenn Douglas considered that it was important to develop a more partnership orientated approach to working together and that a workshop to challenge ways of working would be helpful, the health service could learn a lot from the way local authorities commission services.

5. Mr Gough asked how the Kent and Medway Partnership Board fitted into the structure, Dr Bowes explained that the Partnership Board brought providers and commissioners together as the evolved programme board.

RESOLVED that the Kent and Medwau Joint Health and Wellbeing Board thank Dr Bowes for his presentation and note its contents.

7. Work Programme

(Item 7)

1. Karen Cook asked the Board, which was set up initially for a period of two years, whether they would like to use the next meeting for some workshop and development time offline to determine whether the Board should continue as it is, whether the Terms of Reference should be reviewed and to consider the long term plan. Karen Cook suggested that the Terms of Reference should include children, mental health and Autism for example.

2. Caroline Selkirk suggested that Local Care be brought to alternate Boards rather than every Board, Karen Cook considered that this was sensible and the workshop could look at the forward work programme as well as other Governance issues.

3. It was considered that the workshop be extended to an afternoon on 17 September 2019 and the next agenda setting meeting would also be cancelled.

4. Members considered it important to plan and prepare well.

5. In response to a follow up from Cllr Martin Potter about NHS Healthcheck information for people 40-74 Karen Cook confirmed that this information would be circulated to Members before the workshop.

RESOLVED that the next meeting of the Joint Board, on 19 September 2019, be an afternoon workshop session.

KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD

28 JULY 2020

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD: MEMBERSHIP

Report from: James Williams, Director of Public Health, Medway Council

Andrew Scott-Clark, Director of Public Health, Kent County Council

Author: Jade Hannah, Democratic Services Officer, Medway Council

Karen Cook, Policy and Relationships Adviser (Health), Kent County Council

Summary

This report sets out the current position on the membership of the Kent and Medway Joint Health and Wellbeing Board (Joint Board). The report asks the Joint Board to consider appointing additional voting and non-voting Members as recommended by each respective Health and Wellbeing Board on 18 February 2020 and 26 February 2020.

The report also asks the Joint Board to consider appointing non-voting Members as recommended by the Kent and Medway STP Non-Executive Oversight Group in response to changes in the health landscape across Kent and Medway; by Members at the pre-agenda meeting held on 3 June 2020 to ensure continuity as changes in the health system embed and by Members at the Development Session in September 2019 in recognition of the importance in strengthening relationships and engagement between Councils at all levels.

1. Budget and policy framework

1.1. The membership proposals outlined in this report are a matter for consideration and determination by the Joint Board.

2. Background

2.1. The Joint Board has been established as an advisory Joint Sub-Committee of the Health and Wellbeing Boards of Medway Council and Kent County Council under Section 198(c) of the Health and Social Care Act 2012. The Joint Board was initially established for a time limited period of two years commencing from 1 April 2018.

2.2. On 18 February 2020 and 26 February 2020 respectively, the Health and Wellbeing Boards of Medway Council and Kent County Council agreed to the continuation of the Joint Board together with the terms of reference (including membership) and procedure rules as set out in Appendix 1 to the report.

2.3. In accordance with the membership formula set out in the terms of reference, the current membership is as follows:

2.4. Voting Members of the Kent and Medway Joint Health and Wellbeing Board

2.4.1. The Leader of each Council and up to three other members of each Council nominated by the respective Leaders (or their substitutes):

Kent County Council (KCC) Councillors (4)	**Medway Councillors (4)**
Mr Gough	**Councillor Brake**
Mrs Bell	**Councillor Doe**
Mr Carter	**Councillor Jarrett**
Mrs Chandler	**Councillor Potter**

2.4.2. The Corporate Director of Adult Social Care and Health for Kent and the Assistant Director Adult Social Care for Medway:

Richard Smith (KCC, interim) **Suzanne Westhead** (Medway, interim)

2.4.3. The Corporate Director Children, Young People and Education for Kent and the Director of People - Children and Adults Services for Medway:

Matt Dunkley, CBE (KCC) **Ian Sutherland** (Medway)

2.4.4. The Director of Public Health for each Local Authority:

Andrew Scott-Clark (KCC) **James Williams** (Medway)

2.4.5. Healthwatch representatives for Kent and Medway who must not be a Member of a Health Overview and Scrutiny Committee for either Authority and may each have a named substitute:

Penny Graham (Kent)	**Eunice Lyons-Backhouse** (Medway)
(Substitute: to be advised)	**(Substitute: to be advised**)

2.4.6. A representative of each Clinical Commissioning Group (CCG) (noting that section 197 (7) of the Health and Social Care Act 2012 provides for one person to represent more than one CCG on a Health and Wellbeing Board subject to the agreement of the Board). Each CCG representative may have a named substitute:

Wilf Williams: Accountable Officer, Kent and Medway Clinical Commissioning Group (CCG)

(Substitute: Caroline Selkirk: Director of Health Improvement)

2.5. Non-voting Members of the Kent and Medway Joint Health and Wellbeing Board

2.5.1. The Police and Crime Commissioner – **Matthew Scott**

2.5.2. A representative of the Kent and Medway Local Medical Committee (who may also have a named substitute) – **Dr John Allingham**

(Substitute: Dr Caroline Rickard)

2.5.3. Observer representatives from two District Councils in Kent (aligned with the footprint of the Integrated Care Systems)

Cllr Mrs Angela Harrison (Swale Borough Council)
Cllr Mrs Jenny Hollingsbee (Folkstone and Hythe District Council)

(Note: Current job titles have been used in the report. These may vary from the job titles in the terms of reference).

2.6. The terms of reference provide that the Joint Board may appoint other persons to be non-voting members as it considers appropriate (Paragraph 5 (e), Appendix 1 to the report). Furthermore, with the agreement of the Joint Board, voting or non-voting members from new structures that are emerging in Health may also be included (Paragraph 5 (f), Appendix 1 to the report).

2.7. In line with these provisions, on 28 June 2018, the Joint Board agreed to appoint Dr Robert Stewart as a non-voting member of Joint Board in his capacity as the Clinical Design Director of the Design and Learning Centre for Clinical and Social Innovation. In addition, on 14 December 2018 the Joint Board agreed to appoint Dr Bob Bowes as a voting member of the Joint Board, in his capacity as Chairman of the Strategic Commissioner Steering Group.

3. Membership proposals

3.1. The Joint Board's terms of reference allow for new members to be appointed. As set out in paragraph 2.6 of the report, with the agreement of the Joint Board, voting or non-voting members from new structures that are emerging in Health may be included. On 18 February 2020 and 26 February 2020 respectively, the Health and Wellbeing Boards of Medway Council and Kent County Council agreed, subject to the agreement of the Joint Board:

- to appoint the Clinical Chair of single Kent and Medway CCG as a voting member of the Joint Board (Dr Navin Kumta), and

- to appoint the Senior Responsible Officer of each of the four Integrated Care Partnerships (ICPs) as non-voting members of the Joint Board noting that this will be reviewed when the ICPs are fully mobilised.

(Dartford, Gravesham and Swanley ICP Senior Responsible Officer: Louise Ashley, Chief Executive Dartford and Gravesham NHS Trust

East Kent ICP Senior Responsible Officer: Paul Bentley, Chief Executive of Kent Community Health Foundation Trust

Medway and Swale ICP Senior Responsible Officer: James Devine, Chief Executive Medway Foundation Trust/Martin Riley, Managing Director Medway Community Healthcare

West Kent ICP Senior Responsible Officer: Miles Scott, Chief Executive, Maidstone and Tunbridge Wells NHS Trust)

3.2. Subject to the agreement of the Joint Board, each Health and Wellbeing Board also agreed to re-appoint the Chairman of the System Commissioner Steering Group, Dr Bob Bowes, for a further year. However, it has since been confirmed that this role no longer exists within the Kent and Medway CCG/STP. This was discussed at the pre-agenda meeting held on 3 June and it was recommended that Dr Bob Bowes, Kent and Medway CCG Governing Body Member be appointed in a non-voting capacity for a further year to support the Clinical Chair of the Kent and Medway CCG and in recognition of the work he has done on system transformation and with the Joint Board. As set out in paragraph 2.6 of the report, the Joint Board may appoint other persons to be non-voting members as it considers appropriate.

3.3. With respect to proposals for the appointment of further non-voting members of the Joint Board:

3.3.1. A request has been made by the STP Non-Executive Oversight Group that both the Director of Strategy and Population Health, Rachel Jones, and Director of Health Improvement, Caroline Selkirk, be appointed as non-voting members of the Joint Board.

3.3.2. Consistent with paragraph 2.7 of the report, the Joint Board is asked to consider the re-appointment of the Clinical Design Director of the Design and Learning Centre for Clinical and Social Innovation, Dr Robert Stewart as a non-voting member of the Joint Board.

3.3.3. A request has also been made which was initially discussed at the Joint Board development session on 17 September 2020 to appoint a representative of the Kent Association of Local Councils (KALC) as a non-voting member of the Joint Board. The nominated representative is Councillor John Rivers, President of KALC and Chairman of its Health and Wellbeing Advisory Committee. As requested at the pre-agenda meeting on 3 June 2020, the Chief Executive and President of KALC will give a short presentation to the Joint Board on 28 July 2020 in relation to the work of KALC.

3.4. KALC is a not-for profit membership organisation for Parish, Town and Community Councils and Parish Meetings covering the Kent and Medway footprint. It currently has 97.5% of Councils in membership (312 out of 320). It provides member councils with legal and technical advice, training for

councillors and clerks and has a representational role at county level and also at district level through 13 Area Committees. KALC works closely with the National Association of Local Councils (NALC) on issues of national interest, and NALC also work closely with the Local Government Association. As highlighted by NALC, as the first tier of local government and the closest port of call for residents, local (parish and town) Councils can play a huge role in ensuring that our communities are stronger, healthier and thriving places to live. Duncan Selbie, Chief Executive of Public Health England, told NALC: "What is clear is that local councils are indispensable to the solutions around keeping people in good health."

3.5. Appendix 2 to the report shows how the current membership of the Joint Board compares to the proposed membership outlined in section 3 of the report.

4. Finance, legal and risk management implications

4.1. The legal implications are set out in the body of the report. There are no financial or risk management implications arising from this report.

5. Recommendations

5.1. The Kent and Medway Joint Health and Wellbeing Board is asked to:

a) note the current position on membership of the Joint Board as set out in paragraphs 2.4 and 2.5 of the report; and

b) confirm its agreement to:

- the appointment of the Clinical Chair of single Kent and Medway CCG, as a voting member of the Joint Board, and
- the appointment of the Senior Responsible Officer of each of the four Integrated Care Partnerships (ICPs) as non-voting members of the Joint Board noting that this will be reviewed when the ICPs are fully mobilised

as set out in paragraph 3.1 of the report.

c) consider and decide whether to re-appoint Dr Robert Stewart in his capacity as the Clinical Design Director of the Design and Learning Centre for Clinical and Social Innovation as a non-voting member of the Joint Board.

d) consider and decide whether to appoint the following non-voting members to the Joint Board:

- the Kent and Medway CCG Governing Body Member, Dr Bob Bowes for a further year to support the Clinical Chair of the Kent and Medway CCG,
- the Director of Strategy and Population Health, Kent and Medway CCG, Rachel Jones
- the Director of Health Improvement, Kent and Medway CCG, Caroline Selkirk

- the Chairman of the Kent Association of Local Councils (KALC) Health and Well-Being Advisory Committee, Councillor John Rivers, as the KALC (parish councillor) representative on the Joint Board.

Lead officer contact

Jade Hannah, Democratic Services Officer
Email: jade.hannah@medway.gov.uk Tel: 01634 332008

Karen Cook, Policy and Relationship Adviser (Health)
Email: karen.cook@kent.gov.uk Tel: 03000 415281

Appendices

Appendix 1: Terms of reference and governance arrangements
Appendix 2: Membership comparison

Background papers

None

Appendix 1 - Governance Arrangements for the Kent and Medway Joint Health and Wellbeing Board

1. The Medway Health and Wellbeing Board and the Kent Health and Wellbeing Board are each separately responsible for discharging the following statutory powers and duties for their own areas:

(a) Preparation and publication of a Joint Strategic Needs Assessment (JSNA) – Section 196 of the Health and Social Care Act 2012.

(b) Preparation and publication of a Joint Health and Wellbeing Strategy to meet the needs identified in the JSNA – Section 196 of the Health and Social Care Act 2012

(c) Assessment of need, preparation and publication of a Pharmaceutical Needs Assessment – Section 128A of the National Health Service Act 2006

(d) For the purpose of advancing the health and wellbeing of the people in either Kent or Medway, to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner – Section 195 of the Health and Social Care Act 2012

(e) Encouragement to persons who arrange for the provision of any health related services in Kent and Medway to work closely with the Board – Section 195 of the Health and Social Care Act 2012

(f) Encouragement to persons who arrange for the provision of any health or social care services in Kent and Medway and to persons who arrange for the provision of any health-related services in the area to work closely together – Section 195 of the Health and Social Care Act 2012

(g) Provision of such advice, assistance or other support as thought appropriate by the respective HWBs for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services – Section 195 of the Health and Social Care Act 2012

(h) Involvement in preparation or revision of CCG Commissioning Plans – Section 26 of the Health and Social Care Act 2012

(i) Review of draft CCG Commissioning Plans before the beginning of each financial year (and any in - year revisions to plans) and provision of an opinion to the CCG as to whether or not the draft, or any revisions ,take proper account of the Joint HWB Strategy (with an option to provide an opinion to NHS England) -Section 26 of the Health and Social Care Act 2012

(j) Provision of advice to the local authority that established the HWB of its views on whether the local authority is discharging its duty to have regard to the JSNA and Joint Health and Wellbeing Strategy – Section 196 of the Health and Social Care Act 2012

(k) Provision of a view to NHS England when the annual performance assessment of CCGs is conducted, on the contribution of the CCG to the delivery of the Joint HWB Strategy – Section 26 of the Health and Social Care Act 2012

2. Establishment of an advisory joint sub-committee to be known as the Kent and Medway Joint Health and Wellbeing Board

(a) In exercise of their powers under Section 198 of the Health and Social Care Act 2012 which permits two or more Health and Wellbeing Boards to make arrangements for any of their functions to be exercised jointly, Kent County Council and Medway Council have agreed to establish an advisory joint sub-committee to be called the Kent and Medway Joint Health and Wellbeing Board KAMJHWB) for a time limited period of four years to start from 1st April 2020. On an annual basis, at the request of either Kent's or Medway's Health and Wellbeing Board this may be reviewed.

3. Operating principles

(a) The KAMJHWB is an advisory sub-committee which operates to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and for the purpose of advising on the development of the Sustainability and Transformation Partnership (STP) Plans for Kent and Medway.

(b) It will seek to:

i. Ensure collective leadership to improve health and well-being outcomes across both local authority areas, to enable shared discussion and consensus about the STP across the Kent and Medway footprint in an open and transparent way;

ii. Help to ensure the STP has democratic legitimacy and accountability, to seek assurance that health care services paid for by public monies are provided in a cost-effective manner.

iii. Consider the work of the STP and encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner

iv. Take account of and advise on the wider statutory duties of Health and Social Care Partners

4. Key Functions

(a) To consider and influence the work of the STP focussing on prevention, Local Care and wellbeing across Kent and Medway.

(b) To consider and shape the development of Local Care within the STP which will impact on adult social care delivery in both authorities, advising the Kent and Medway Health and Wellbeing Boards accordingly.

(c) To give advice to the STP in developing clear plans and business cases to assist commissioners in making best use of their combined resources to improve local health and well-being outcomes, particularly relating to the Local Care and Prevention work streams, making recommendations to the Kent and Medway Health and Wellbeing Boards on support that could be provided.

(d) To keep NHS commissioning plans under review, insofar as they relate to STP Plans to ensure they are taking into account the Kent and Medway JSNAs and local HWB Strategies, referring back to the STP Programme Board and respective Kent and Medway Health and Wellbeing Boards where they do not.

(e) To champion integration in local care delivery, including working with the STP to establish a Kent and Medway Local Care Board

(f) To support the development of the Clinical Strategy

(g) To ensure alignment of the Kent and Medway JSNAs with population health needs to inform the STP Case for Change and the associated Clinical Strategy

(h) To consider and advise on the development of the STP Preventative work-stream given it is heavily focussed on Public Health functions within both upper-tier authorities

(i) To consider and advise on the development of options for the local authorities' role in a Strategic Commissioner arrangement with Health – the engagement in which remains a matter for each of the local authorities.

(j) To consider options for the Local Authority role in the development of Integrated Care Systems (previously known as Accountable Care Partnerships), the engagement in which remains a matter for each of the local authorities.

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5. Membership

(a) The Chairman of the KAMJHWB will be appointed at the first meeting of the Board and thereafter at the first meeting of the Board after the annual meetings of Kent County Council and Medway Council. It is expected that the position of Chairman will be rotated between the chairmen of the constituent authorities' Health and Wellbeing Boards on an annual basis.

(b) The Vice-Chairman of the Joint Board will also be appointed at the first meeting of the Board and thereafter at the first meeting of the Joint Board after each Kent and Medway Annual Council meetings. It is expected that the position of vice-chairman will also be rotated on an annual basis and will be the chairman of the authority's Health and Wellbeing Board who is not the chairman of the KAMJHWB.

(c) Voting members of the KAMJHWB are as follows:

- The Leader of each Council and up to three other members of each council nominated by the respective leaders (or their substitutes)
- The Director of Adult Social Services for Kent and the Assistant Director Adult Care Services for Medway
- The Director of Children's Services for Kent and the Director of Children and Adults for Medway
- The Director of Public Health for each local authority
- Representatives of the Local Healthwatch organisations for Kent and Medway who must not be a Member of a Health Overview and Scrutiny Committee for either authority and who may each have a named substitute
- A representative of each Clinical Commissioning Group (noting that section 197 (7) of the Health and Social Care Act 2012 provides for one person to represent more than one CCG on a HWB subject to the agreement of the Board). Each CCG representative may have a named substitute.

(d) Non Voting Members of the KAMJHWB are as follows:

- The Police and Crime Commissioner
- A representative of the Kent and Medway Local Medical Committee (who may also have a named substitute)

(e) The KAMJHWB may appoint other persons to be non-voting members as it considers appropriate. If at any time after the establishment of the Joint Board either of the authorities' Health and Wellbeing Boards wish to appoint additional non-voting members of the Board this may only be done after consultation with the KAMJHWB. In addition there should be observer representatives from two District Councils in Kent (aligned with the footprint of the Integrated Care Systems)

(f) With the agreement of the Joint Board, voting or non-voting members from new structures that are emerging in Health may also be included.

6. Procedure Rules

(a) **Conduct**. Members of the KAMJHWB must comply with the relevant Council's Code of Conduct.

(b) **Registration and Declaration of Interests**. Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the KAMJHWB. A register of interests is held by Kent County Council and Medway Council. Members of the KAMJHWB must register interests as required by the relevant Council's code of conduct. A Member of the Board or any substitute may not participate in a discussion of or vote on any matter in which he or she has a DPI or other significant interest (both those already registered and those disclosed at the meeting) and must withdraw from the room during such discussion.

(c) **Frequency of Meetings**. The KAMJHWB will usually meet quarterly. The date, time and venue of meetings are fixed in advance by the JKAMHWB. At the end of the time limited period the Board may agree to continue its arrangements with approval through the relevant Council governance for each authority.

(d) **Meeting Administration**. Administration for the KAMJHWB will be rotated annually between Kent County Council and Medway Council.

- The Joint Board will give at least five clear working days' notice in writing to each member of every ordinary meeting of the KAMJHWB, to include any agenda of the business to be transacted at the meeting.
- Papers for each KAMJHWB meeting are published at least five clear working days in advance.
- Late papers may be added to the agenda at less than five days' notice only where the Chairman is satisfied that the business is urgent by way of special circumstances which must be specified in the minutes.
- Meetings will take place in public with provision for exclusion of the press and public where confidential or exempt information is likely to be disclosed as defined in the Local Government Act 1972.

(e) **Special Meetings**. The Chairman or Vice-Chairman may convene special meetings of the KAMJHWB in addition to scheduled meetings as considered necessary

(f) **Minutes.** Minutes of all of KAMJHWB meetings are prepared recording:

- the names of members of the KAMJHWB (and any substitutes) who are present at a meeting and any apologies for absence
- details of all proceedings and resolutions of the meeting
- Minutes are normally published and circulated before the next meeting of the KAMJHWB, when they are submitted for approval by the KAMJHWB and are signed by the Chairman.

(g) **Agenda.** The agenda for each meeting normally includes:

- Apologies for absence
- Declarations of interest
- Minutes of the previous meeting for approval and signing
- Reports to the KAMJHWB
- Any item which a member of KAMJHWB wishes included on the agenda provided it is relevant to the Terms of Reference of the Board must be notified to the Chairman and relevant Democratic Services Officer at least one calendar month before the meeting however any decision to include an item on any agenda rests with the Chairman and Vice-Chairman following advice from the relevant officers.

(h) **Absence of Members and of the Chairman**. If a member is unable to attend a meeting, they may provide an appropriate substitute to attend in his/her place (noting that CCG, LMC and Healthwatch representatives must have named substitutes). The Democratic Services Officer for the meeting should

be notified of any absence and/or substitution prior to the meeting. Any substitute member must register his/her interests, in accordance with either the Medway or Kent Councillor Code of Conduct and these must be published before participation as a formal member of the Joint Board is permitted.

(i) The Chairman presides at KAMJHWB meetings if he/she is present. In their absence the Vice-Chairman presides. If both are absent, the KAMJHWB appoints from amongst its members an Acting Chairman for the meeting in question.

(j) All matters coming before the KAMJHWB shall be decided by a majority of the members of the Board present and voting thereon at the meeting. In the case of an equality of votes the person presiding at the meeting shall have a second or casting vote.

(k) **Quorum.** A third of the total number of voting members of the Board, and at least one representative from each of the two councils, form a quorum for the KAMJHWB meetings. No business shall be transacted at any meeting of the KAMJHWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman must either suspend business until a quorum is re-established or declares the meeting at an end.

(l) **Adjournments**. By the decision of the Chairman, or by the decision of a majority of those members present, meetings of the KAMJHWB may be adjourned at any time to be reconvened at any other day, hour and place, as the KAMJHWB decides.

(m) **Order at Meetings**. At all meetings of the KAMJHWB it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. The Chairman decides all questions of order that may arise.

(n) **Overview and scrutiny**. Overview and scrutiny (within the meaning of the Local Government Act 2000 and The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013) will be the responsibility of each constituent Authority and the appropriate scrutiny arrangements of each Authority will apply. No member of a Health Overview and Scrutiny Committee from either Kent County Council or Medway Council may also be a member (or substitute member) of the KAMJHWB.

Appendix 2 - Position on Membership

Voting Members				
No.	Current Membership	No.	Proposed Membership	Comments
1	Medway Council, Leader Cllr Alan Jarrett	1	Medway Council, Leader Cllr Alan Jarrett	No Change
2	Medway Council Elected Representative Cllr David Brake	2	Medway Council Elected Representative Cllr David Brake	No Change
3	Medway Council Elected Representative Cllr Howard Doe	3	Medway Council Elected Representative Cllr Howard Doe	No Change
4	Medway Council Elected Representative Cllr Martin Potter	4	Medway Council Elected Representative Cllr Martin Potter	No Change
5	KCC Leader Mr Roger Gough	5	KCC Leader Mr Roger Gough	No Change
6	KCC Elected Representative Mrs Clair Bell	6	KCC Elected Representative Mrs Clair Bell	No Change
7	KCC Elected Representative Mr Paul Carter, CBE	7	KCC Elected Representative Mr Paul Carter, CBE	No Change
8	KCC Elected Representative Mrs Sue Chandler	8	KCC Elected Representative Mrs Sue Chandler	No Change
9	Medway Council, Assistant Director Adult Social Care Suzanne Westhead (Interim)	9	Medway Council, Assistant Director Adult Social Care Suzanne Westhead (Interim)	No Change
10	Kent County Council, Corporate Director Adult Social Care and Health Richard Smith (Interim)	10	Kent County Council, Corporate Director Adult Social Care and Health Richard Smith (Interim)	No Change
11	Medway Council, Director of Children and Adults Ian Sutherland	11	Medway Council, Director of Children and Adults Ian Sutherland	No Change
12	Kent County Council, Corporate Director Children, Young People and Education Matt Dunkley, CBE	12	Kent County Council, Corporate Director Children, Young People and Education Matt Dunkley, CBE	No Change
13	Medway Council, Director of Public Health James Williams	13	Medway Council, Director of Public Health James Williams	No Change
14	Kent County Council, Director of Public Health Andrew Scott-Clark	14	Kent County Council, Director of Public Health Andrew Scott-Clark	No Change
15	Local Healthwatch Representative Kent Penny Graham	15	Local Healthwatch Representative Kent Penny Graham	No Change
16	Local Healthwatch Representative Medway Eunice Lyons-Backhouse	16	Local Healthwatch Representative Medway Eunice Lyons-Backhouse	No Change
17	CCG Representative – Glenn Douglas	17	AO of the new single K&M CCG Wilf Williams	The membership formula allows for a representative of each CCG.
18	CCG Representative – Caroline Selkirk (East Kent)			
19	CCG Representative – Ian Ayres (West Kent)			
20	Chairman of Strategic Commissioner Steering Group - Dr Bob Bowes		-	Position no longer exists within the K&M CCG/STP
		18	Clinical Chair of new K&M CCG Dr Navin Kumta	Newly created post in the single CCG. K&M HWBs have agreed appointment subject to Joint Board confirming agreement.

Non - Voting Members				
No.	Current Membership	No.	Proposed Membership	Comments
21	Kent Police and Crime Commissioner Matthew Scott	19	Kent Police and Crime Commissioner Matthew Scott	No Change
22	Kent Local Medical Committee Dr John Allingham	20	Kent Local Medical Committee Dr John Allingham	No Change
23	District Council Representative Nominated by Kent Chiefs Cllr Mrs Angela Harrison	21	District Council Representative Nominated by Kent Chiefs Cllr Mrs Angela Harrison	No Change
24	District Council Representative Nominated by Kent Chiefs Cllr Mrs Jenny Hollingsbee	22	District Council Representative Nominated by Kent Chiefs Cllr Mrs Jenny Hollingsbee	No Change
25	Clinical Design Director for the Design and Learning Centre for Clinical and Social Innovation – Dr Robert Stewart	23	Clinical Design Director for the Design and Learning Centre for Clinical and Social Innovation – Dr Robert Stewart	Re-appointment to be considered at the Joint Board on 28 July 2020.
		24	KALC (parish and town council representation) Chairman of the KALC Health and Well-Being Advisory Committee, Councillor John Rivers	Appointment to be considered at the Joint Board on 28 July 2020.
		25	Kent and Medway CCG Governing Body Member Dr Bob Bowes	Appointment for a further year to be considered at the Joint Board on 28 July 2020. To support transition of Clinical Chair, K&M CCG onto the Joint Board, recognising existing input to the Joint Board.
		26	Director of Strategy and Population Health Rachel Jones	Appointment to be considered at the Joint Board on 28 July 2020. Requested by STP Non-Exec Oversight Group.
		27	Director of Health Improvement Caroline Selkirk	Appointment to be considered at the Joint Board on 28 July 2020. Requested by STP Non-Exec Oversight Group.
		28	Medway and Swale ICP Senior Responsible Officer (SRO) James Devine, Chief Executive Medway Foundation Trust Martin Riley, Managing Director Medway Community Healthcare	The ICPs will operate in shadow form until April 2021, therefore it is recommended that each ICP lead be appointed as a non-voting member at this stage to be reviewed at a later date. K&M HWBs have agreed appointment subject to Joint Board confirming agreement.
		29	East Kent ICP SRO Paul Bentley, Chief Executive of Kent Community Health Foundation Trust	
		30	West Kent ICP SRO Miles Scott, Chief Executive, Maidstone and Tunbridge Wells NHS Trust	
		31	Dartford, Gravesham and Swanley ICP SRO Louise Ashley, Chief Executive Dartford and Gravesham NHS Trust	

KENT AND MEDWAY JOINT HEALTH AND WELLBEING BOARD

28 JULY 2020

COVID-19 LOCAL OUTBREAK CONTROL PLAN BRIEFING

Report from: Andrew Scott-Clark, Director of Public Health for Kent County Council

James Williams, Director of Public Health for Medway Council

Author: Dr Logan Manikam, Interim Public Health Consultant

Summary

This report provides an overview of the response and recovery strategy to protect Kent and Medway's populations from COVID-19 impacts. It describes actions that Kent County Council (KCC) and Medway Council (MC), in partnership with key stakeholders, have taken to develop the COVID-19 Local Outbreak Control Plan (LOCP).

The report also sets out the governance arrangements and framework, through which KCC and MC will collaborate to deliver their statutory functions to protect their populations and reduce the spread of COVID-19.

1. Budget and policy framework

1.1. As part of the Department of Health and Social Care's COVID-19 response and recovery strategy, Upper Tier and Unitary Local Authorities in England were mandated to develop a COVID-19 Local Outbreak Control Plan to reduce the viruses' spread.

1.2. With provision of £300M in national government funding to support the Plan's delivery, the COVID-19 Local Outbreak Control Plan will follow national outbreak management standards and put in place local measures to prevent, identify, and contain COVID-19 outbreaks. This plan was published online on 30 June 2020 (Appendix 1).

2. Background

2.1. Building on KCC and MC's existing health protection systems, a Kent and Medway COVID-19 Health Protection Committee (HPC) was established on 1

June 2020 to provide strategic oversight for both the development and delivery of the COVID-19 Local Outbreak Control Plan.

2.2. The HPC is led by KCC and MC's Directors of Public Health and consists of key partners from Public Health England's local health protection teams, NHS England & NHS Improvement to ensure an integrated response. Officer representatives from Kent's District Councils will also be fully involved given their environmental health responsibilities. Full membership details can be found in the HPC Terms of Reference set out in Appendix 2.

2.3. The HPC meets weekly and serves to ensure effective system wide collaboration. Reports will be provided to key stakeholders in line with paragraphs 2.4.8 and 3.1 of the report. It is, however, recognised that both councils will maintain their own specific governance and oversight arrangements for their organisation's pandemic response.

2.4. In accordance with guidance from the Department of Health and Social Care and local adaptation, the Kent and Medway COVID-19 Local Outbreak Control Plan is centred around 8 core themes:

2.4.1. Care Homes and Schools

Planning for local outbreaks in care homes and schools including defining monitoring arrangements, potential scenarios and required response planning. Additional local guidance documents, tools and action plans have already been developed locally such as the COVID-19 health and safety checklist for school headteachers.

2.4.2. High risk places, locations, and communities

Identifying and planning how to manage high risk places, locations and communities of interest by defining preventative measures, outbreak management strategies and community engagement plans.

2.4.3. Local testing capacity

Several different testing services will be established to ensure that testing is accessible to the entire population. These include:

Regional Testing Sites (RTS)

These are a network of drive-through sites in the region. Currently there is a Regional Test Site in Ashford. Further work is ongoing to put in place an additional RTS in Manston.

Satellite Testing Sites

These are placed at sites that have a particularly urgent or significant need (i.e. hospitals, remote locations). There are currently satellite sites on the Hoo Peninsula and at Medway Maritime Hospital NHS Foundation Trust.

Mobile Testing Sites

These travel regionally and service areas of Kent and Medway not covered by regional or satellite test sites. Currently, mobile units can be deployed to locations in Maidstone, Swale, Canterbury, Ashford,

Dover, Folkestone and Medway. Work is ongoing to establish a site in Margate (pending the outcome of the establishment of an RTS at Manston).

Testing in Hospitals & Care Homes

Hospitals and Care homes are eligible for immediate, prioritised testing the event that a member of staff, patient or resident shows symptoms or has been notified to be in contact with someone who has the virus. They're also eligible for antibody testing as part of the government's surveillance strategy to allow for a better understanding of post-infection immunity as well as the UK population virus's prevalence.

Further Test Sites

The Department of Health and Social are in the process of developing localised testing innovations. These microsites could be placed in communities and enable people to walk or cycle to them.

2.4.4. Contact Tracing in Complex Settings

Assessing local and regional contact tracing and infection control capability in complex settings and the need for mutual aid (e.g. identifying specific local complex communities of interest and settings, developing assumptions to estimate demand & options to scale capacity if needed).

2.4.5. Data Integration and Monitoring

Receiving and acting on data and intelligence, including epidemiology and Early Warning indicators, provided from sources including the Public Health England Epidemiology Cell, NHS Test and Trace, the National Joint Biosecurity Centre and other local data sources.

2.4.6. Supporting and protecting vulnerable groups

Consideration of specific requirements to address the challenges faced by "Shielders" as well as other residents and groups who may need additional support due to self-isolation requirements and other challenges arising from the current situation.

2.4.7. Communications Strategy

Whilst not part of the national requirement, public communication is essential, primarily as it's the local authority responsibility to "warn and inform" but it also makes up a key standard in managing outbreaks effectively. There is a need to ensure individuals and specific communities are aware of the risks associated with increased COVID-19 mortality and morbidity and how they can protect themselves and others.

2.4.8. Formation of Local Boards

In addition to the HPC, additional local working groups and boards should be established to facilitate command and control and the delivery of the overall objectives.

Strategic Co-ordinating Group
There is already a multi-agency Strategic Co-ordinating Group (SCG) in place in Medway and Kent with the SCG part of the Kent Resilience Forum (KRF). The HPC will report through the SCG to co-ordinate and partner with the wider system to support delivery of the COVID-19 Local Outbreak Control Plan.

Local Outbreak Engagement Board (LOEB)
The aim of the Outbreak Engagement Board is to provide political ownership and wider public engagement and communication of the outbreak response.

3. Advice and analysis

3.1. Building on Section 2.4.8, in the event of an outbreak the HPC will work with the KRF who will deliver the COVID-19 Local Outbreak Control Plan by working through pre-existing structures that are in place with local stakeholders and organisations. The HPC will provide regular updates to the LOEB on the COVID-19 Local Outbreak Control Plan and outbreaks within the region. See Appendix 3 to the report for a summary of the governance structure.

4. Risk management

4.1. There are several known risks which include; (1) compliance & effects of social distancing measures, (2) 2nd wave occurring, (3) further excess deaths (if 2nd wave occurs during flu season) & (4) additional pressure on Kent & Medway's health and social care systems. The HPC will consider & aim to mitigate all these risks via the delivery of the COVID-19 Local Outbreak Control Plan.

5. Consultation

5.1. The COVID-19 Local Outbreak Control Plan has been developed in consultation with a wide range of stakeholders including Kent's District Councils, Kent Resilience Forum, Kent and Medway Clinical Commissioning Group, NHS England and Improvement, General Practitioners, NHS Trusts, Public Health England (Kent and Medway Health Protection Team, Contact Tracing Cell), Kent Police, British Transport Police and the Kent Fire and Rescue Services. Public and patient input will be solicited via Health Watch and other local organisations.

6. Climate change implications

6.1. Not applicable

7. Financial implications

7.1. As described in paragraph 1.2 of the report, financial resources have been allocated to Medway Council and Kent County Council through the Local Authority test and trace service support grant, allocations for which have used the 2020/21 Public Health Grant allocations as a basis for distributing the

funding. Medway Council received £1,592,918 and Kent County Council received £6,311,401.This non-recurrent funding covers an 18-month period and will be earmarked for health protection and recovery activities outlined in the COVID-19 Local Outbreak Control Plan.

8. Legal implications

8.1. Kent County Council and Medway Council, under the leadership of the Directors of Public Health, have a statutory duty to protect the population's health by responding to and managing communicable disease outbreaks which requires urgent investigation and presents a public health risk.

8.2. The legal context for the Councils' response to COVID-19 sits within the following Acts:

- The Coronavirus Act 2020
- Health and Social Care Act 2012
- Public Health (Control of Disease) Act 1984

8.3. The Kent and Medway Joint Health and Wellbeing Board has been established as an advisory joint sub-committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012 for a time limited period of four years from 1st April 2020.

8.4. The Joint Board seeks to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner and ensure collective leadership to improve health and well-being outcomes across both local authority areas.

8.5. The Joint Board is advisory and may make recommendations to the respective Kent and Medway Health and Wellbeing Boards.

8.6. The duties of Health and Wellbeing Boards, established by s.195 of the Health and Social Care Act 2012 and set out in the existing Terms of Reference for Medway's Board include the following:

- To encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in Medway.
- To encourage persons who arrange for the provision of any health related services (i.e. services that may have an effect on the health of individuals but are not health or social care services) in Medway to work closely with the Board.
- To encourage persons who arrange for the provision of any health or social care services in Medway and those who arrange for the provision of any health-related services in its area to work closely together.
- To involve users and the public in the work of the Board, as appropriate.

8.7 As such, the Kent and Medway Joint Health and Wellbeing Board is able to take on the function of the Local Outbreak Engagement Board (LOEB) referred to in paragraph 2.4.8, provided the role of the LOEB remains advisory.

8.8 The terms of reference of Medway's and Kent's Health and Wellbeing Boards are set out in Appendices 4 and 5 of the report respectively.

9. Recommendations

9.1. Members are recommended to

a) Agree, in principle, that this Board should fulfil the role of the Local Outbreak Engagement Board (i.e. to provide political ownership and public-facing engagement and communication for outbreak response) subject to formal agreement of both the Medway and Kent Health and Wellbeing Boards.

b) recommend to both Councils' Health and Wellbeing Boards that they formally delegate the function of the LOEB to this Board and agree the terms of reference of the LOEB to be fulfilled by this Board.

Lead Officer Contact

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Appendices

Appendix 1 - COVID-19 Local Outbreak Control Plan
Appendix 2 - Health Protection Committee Terms of Reference
Appendix 3 - Governance Structure
Appendix 4 – Medway Health and Wellbeing Board Terms of Reference
Appendix 5 – Kent Health and Wellbeing Board Terms of Reference

Background papers

Local Outbreak Control Plans (Department of Health and Social Care, 22 May 2020

Appendix 1

Kent Resilience Forum

PREPARING FOR EMERGENCIES IN KENT AND MEDWAY

Local Outbreak (COVID-19) Control Plan

TO ACTIVATE THIS PLAN, GO TO SECTION 7.2

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

Completion Date	June 2020
Version	v1.0
Review Date	25th June 2020
Classification	Official

All enquiries relating to this document should be sent to:

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Issue & Review Register

Summary of changes	Issue number & date	Approved by
Draft with headings & introductions	v.0.1 31/05/2020	N/A
Various notes and Schools Section Added	v.0.2 03/06/2020	N/A
Various notes and Care Homes Section Added	v.0.3 05/06/2020	N/A
Updated draft incorporating comments and contributions from Colin Thompson (CT) + Wendy Jeffreys (WJ)	v.0.4 07/06/2020	N/A
Updated draft incorporating comments and contributions from CT + Allison Duggal (AD) + Steve Scully (SS) + Rachel Pudney (RP)	v.0.5 14/06/2020	N/A
Updated draft incorporating comments and contributions from CT + SS + AD + RP + WJ + Andrew Scott Clark (ASC) + James Williams (JW) + Sarah Leaver (SL) + Richard Doyle (RD) + Abraham George (AG) + Su Ormes (SO) + Nicola Wilson (NW) + Andy Jeffery (AJ) + District Council Environmental Health Teams + KRF Testing Workstream + John Littlemore (JL) + Sarah Hammond (SH) + Gail Locock (GL) + Simon Thompson (ST) + Tracey Beattie (TB) + Rob Wiles (RW) + Mariana Vasiliou (MV) + Penny Button (PB) + Sheila Davison (SD) + Alex Dawson (AD) + Michelle Cheyne (MC) + Karen Williams (KW) + David Whiting (DW) + Samantha Bennett (SB)	v.0.6 22/06/2020	N/A
Updated draft incorporating comments and contributions from AD + WJ + JW + SO + SB + ASC + AJ + SS + RP + BC + MC	v.0.7 24/06/2020	N/A
Final draft incorporating comments and contributions from Barbara Edwards (BE) + MC + JW + CT	v.1.0 28/06/2020	JW + ASC + RP

Compiled by: Logan Manikam and Valentina Vos (for the KRF COVID-19 Health & Social Care Cell) **Date:** June 2020

Approved by: KRF COVID-19 Strategic Coordinating Group **Date:** June 2020

Contents

Tables & Figures

Abbreviations

BAME	Black Asian & Minority Ethnic Groups
CAG	Confidentiality Advisory Group
CEO	Chief Executive Officer
CTAS	Contact Tracing Advisory Service
DHSC	The Department of Health and Social Care
DPH	Directors of Public Health
EHO	Environmental Health Officer
EPPR	Emergency Prevention, Preparedness and Response Team (SE regions, NHS England)
GDPR	General Data Protection Regulations
GP	General Practice
HPB	Health Protection Board
HSCC	Kent Resilience Forum – Health and Social Care Cell
JBC	Joint Biosecurity Centre
KCC	Kent County Council
KRF	Kent Resilience Forum
LA	Local Authority
LOEB	Local Outbreak Engagement board (Joint Health and Wellbeing Board)
LOCP	Kent and Medway Local COVID-19 Outbreak Control Plan
LRF	Local Resilience Forum
LHRP	Local Health Resilience Partnership
MAIC	Kent Resilience Forum – Multi Agency Information Cell
MC	Medway Council
NHS	National Health Service
NHS T&T	NHS Test and Trace
NPI	Non-pharmaceutical interventions
PPE	Personal Protective Equipment
PHC	Public Health Consultant
PHE HPT	Public Health England South East - Kent and Medway Health Protection Team
KRF SCG	Kent Resilience Forum - Strategic Coordinating Group
SITREP	Situation Report
SOP	Standard Operating Procedure
SPOC	Single Point of Contact
TCG	Tactical Coordinating Group
UTLA	Upper Tier Local Authority
ULA	Unitary Local Authority
VCS	Voluntary and Community Sector
WHO	World Health Organisation

Executive Summary

As part of the UK government's COVID-19 recovery strategy, the NHS Test and Trace service was launched on 28th May 2020 with the primary objective to control the COVID-19 reproduction (R) rate, reduce the spread of infection, save lives, and help return life to as normal as possible for as many people as possible in a way that is safe, protects health and care systems, and restarts the economy.

Achieving these objectives requires a co-ordinated effort between local government, the National Health Service, Public Health England, police and other relevant organisations at the centre of outbreak response set out in a Local Outbreak Control Plan.

In Kent and Medway, the Kent Resilience Forum COVID-19 Local Outbreak Control Plan builds on existing health protection plans already in place between Kent County Council, Medway Council, Public Health England - South East, the 12 Kent District and Borough Council Environmental Health Teams, the Strategic Coordinating Group of the Kent Resilience Forum, Kent and Medway Clinical Commissioning Group and other key partners.

Summarised in 8 themes, the Kent Resilience Forum COVID-19 Local Outbreak Control Plan sets out how we aim to protect Kent and Medway's population by:

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

The themes are;

1. Governance structures that have been established and are led by the Kent and Medway COVID-19 Health Protection Board and supported by the Strategic Coordinating Group of the Kent Resilience Forum, Kent County Council & Medway Council through the Kent and Medway Joint Health and Wellbeing Board. In addition, both Kent County Council and Medway Council have specific oversight arrangements to take account of their public duties and responsibilities (**Section 4**)
2. Arrangements to manage care homes & education setting outbreaks including defining monitoring arrangements, identifying potential scenarios and planning required responses (**Section 5**)
3. Arrangements in place to manage outbreaks in other high-risk places, locations and communities of interest including sheltered housing, transport access points & detained settings including defining monitoring arrangements, identifying potential scenarios, and planning required responses (**Section 5**)
4. Managing the deployment and prioritisation of services available for local testing which allows for a population level swift response. This includes delivering tests to isolated

individuals, establishing local pop-up sites and hosting mobile testing units at high-risk locations (**Section 6**)

5. Monitoring local and regional contact tracing and infection control capability in complex settings and the need for mutual aid, including developing options to scale capacity if needed (**Section 7**)
6. Integrating national and local data and scenario planning through the Joint Biosecurity Centre Playbook (**Section 8**)
7. Supporting vulnerable local people to get help to self-isolate and ensuring services meet the needs of diverse communities (**Section 9**)
8. Communicating with the public and local partners in Kent and Medway; essential for managing outbreaks effectively (**Section 10**)

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

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

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1. Introduction

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of an unknown cause detected in Wuhan City, Hubei Province, China [1]. On 12 January 2020 it was announced that a novel coronavirus had been identified, this virus is referred to as SARS-CoV-2, and the associated disease as COVID-19 [2]. On 11th March 2020 the WHO declared the COVID-19 outbreak a pandemic [3]. As of 25 June 2020, over 9.1 million cases have been diagnosed globally, with more than 473,000 fatalities [4]. The total number of confirmed cases in the UK is published by the Department of Health and Social Care (DHSC) and local numbers by Public Health England (PHE) are available here [5]

The UK Government's response strategy for managing the COVID-19 pandemic is now entering its next phase. Up to date information about the national response can be found here [6]. As places such as schools and shops start to open and as the NHS Test and Trace service [7] becomes more established, additional support is required to ensure this is delivered safely and effectively.

Under the Health and Social Care Act 2012 [8], Directors of Public Health (DPH) in upper tier (UTLA) and unitary (ULA) local authorities have a specific duty to protect the population's health. They must ensure plans are in place to respond to and manage threats such as communicable disease outbreaks which present a public health risk. DPHs fulfil this duty through collaboration across a range of partners. These include local authority (LA) environmental and public health teams (including consultants in public health), Public Health England (PHE), National Health Service (NHS) organisations and other agencies.

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

1.1. Purpose & Scope

The Kent Resilience Forum COVID-19 Local Outbreak Control Plan (LOCP) will augment existing health protection arrangements in place within Kent and Medway. This plan will enable additional specific action to be taken to address COVID-19 outbreaks. Its aims and themes are set out in the **Executive Summary** (see page 6).

The LOCP is based on Public Health Outbreak Management Standards [9], and health protection functions for local government. These functions are outlined in "Health Protection in Local Government Guidance [10] (placing primary health protection roles at both District/Borough and County Council level, with other functions sitting with PHE and the Guiding Principles for Effective Management of COVID-19 at a Local Level [11]

The LOCP includes;

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

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

1.2. Linked plans

The LOCP builds on the following plans:

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

2. Kent and Medway in Context

An estimated 1.8 million people live in Kent and Medway [12]. KCC is an UTLA and is comprised of 12 borough & district councils inhabited by circa 1.5 million people [13]. MC is a ULA with circa 280,000 residents [14]. Together, they make up one of the most densely populated areas in England.

2.1 Health Needs of Residents

- Life expectancy at birth is similar to England's national average [15] in Kent and lower than national average in Medway for men (79.9 in Kent, 79.0 in Medway) and women (83.4 in Kent, 82.6 in Medway) [16].
- Adult smoking (15% in Kent, 14.7% in Medway) and overweight or obesity prevalence (64.2 % in Kent, 69.6% in Medway) are similar to England's national average [16]. Obesity is known to be a COVID-19 risk-factor [17].
- Increasing age is known to be a COVID-19 risk factor [17] and 19.4% of Kent's [18] and 15.9% of Medway's residents [14] are aged 65+.
- Non-white ethnicity is also known to be a COVID-19 risk-factor [17]. In Kent, 6.6% of the population are of Black Asian and Minority Ethnic (BAME) origin with the largest single BAME group represented by Asian Indians at 1.2% of the total population [19]. In Medway, 10.4% of the total population identified as BAME with Asian Indians the largest proportion at 2.7% [20]
- A 2016 report found there to be significant inequalities in the health outcomes, health behaviours, risk factors and wider health determinants among Kent and Medway's residents, with premature mortality from respiratory disease 3 times higher amongst the most deprived compared with the least deprived [21].
- The mortality gap between least and most deprived is widening suggesting increasing health inequalities [15].

2.2 Health & Social Care Landscape

The *Kent and Medway Sustainability and Transformation Plan* is aiming to establish an Integrated Care System by April 2021 [22]. Organisations involved in the delivery and/or support of Kent and Medway's residents' health and social care needs include:

- 220 + General Practice (GP) Surgeries
- 24 Hospitals
- 342 Pharmacies
- 429 Dentists
- 42 Primary Care Networks
- 4 Integrated Care Partnerships (Dartford, Gravesham & Swanley; East Kent; Medway & Swale; and West Kent)
- 4 Acute Trusts (including 3 Foundation Trusts)
- 1 UTLA (KCC)

- 1 ULA (MC)
- 1 Mental Health Trust
- 2 Community Health Trusts
- 1 Ambulance Service
- 1 Clinical Commissioning Group (CCG)

2.3 The Impact of COVID-19

Cases

There have been 5,974 lab-confirmed cases of COVID-19 in Kent and Medway reported to PHE as of 20th June 2020 [23]. This is a rate of 321 cases per 100,000 population.

3. Legal Context

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

3.1. Coronavirus Act 2020

Under the Coronavirus Act [24], the Health Protection (Coronavirus Restriction) (England) Regulations 2020 as amended [25], set out the current restrictions and regulations in place which, when taken together, create a lockdown situation. Any easing of lockdown comes from amending or lifting of these national regulations. The powers of the police to enforce lockdown measures also flow from these regulations.

'Localised' lockdown would require further government regulations that are designed to be used locally. Currently there are no such regulations. The Joint Biosecurity Centre (JBC) will be issuing further information about how local movement restrictions may need to be instated if infections increase again.

3.2. Health Protection Regulations 2010 (as amended)

The powers contained in the suite of Health Protection Regulations 2020 as amended [25], sit with district and borough council and ULA Environmental Health teams.

The Health Protection (Local Authority Powers) Regulations 2010 [26] allows a LA to serve notice on any person with a request to co-operate for health protection purposes to prevent, protect against, control or provide a public health response to the spread of infection which could present significant harm to human health.

The Health Protection (Part 2A Orders) Regulations 2010 [27] allow a LA to apply to a magistrates' court for an order requiring a person to undertake specified health measures for a maximum period of 28 days. These Orders are a last resort, requiring specific criteria to be met and are labour intensive. These Orders were not designed for the purpose of 'localised' lockdowns, so it is possible that there may be a reluctance by the Courts to impose such restrictions and the potential for legal challenge.

3.3. Data Sharing

There will be a proactive approach to sharing information between local responders, in line with the instructions from the Secretary of State, the statement of the Information Commissioner on COVID-19 and the Civil Contingencies Act 2004 [28]. Further details regarding data sharing and information governance can be found in **Section 8.4**

4. Theme 1 - Governance Structure

The *Guiding Principles for Effective Management of COVID-19 at a Local Level* sets out that ULA and UTLA Chief Executives, in partnership with the Director of Public Health and Public Health England Health Protection Team, are responsible for signing off the Local Outbreak Control Plan [11]

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

4.1. Kent and Medway Health Protection Board

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

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

4.2. Kent Resilience Forum – Strategic Coordinating Group

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

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

4.3. Kent and Medway Local Outbreak Engagement Board

As stipulated by the DHSC, there is a need for a Local Outbreak Engagement Board (LOEB) to provide political ownership & facilitate public and stakeholder engagement for the COVID-19 Local Outbreak Control Plan. In Kent and Medway, the LOEB will be the Kent and Medway Joint

Health and Wellbeing Board. Operationally there are additional layers of engagement and governance, that sit within the structures of KCC and MC. These structures serve to enable the LAs to discharge their specific public health responsibilities. They also serve to ensure oversight of other elements of LA specific responsibilities. For example, there will be regular member engagement through the Kent Leaders Forum comprising elected council leaders from all LAs across Kent and Medway.

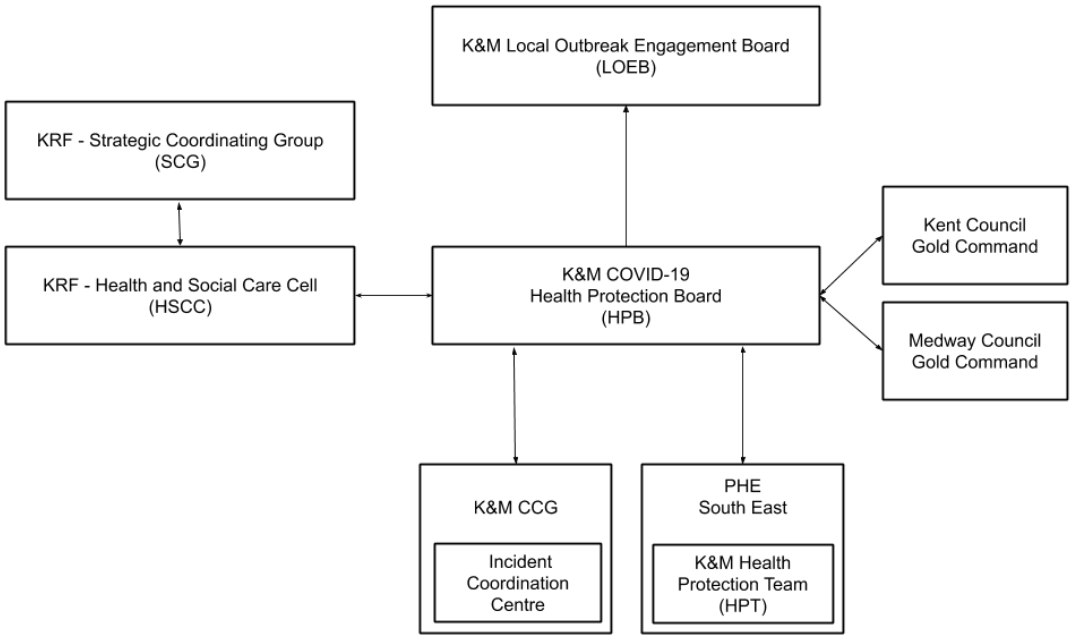

Figure 1 – Governance Structure of Local Boards

5. Themes 2 & 3 - Identification of Complex Settings

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

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

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

1. outline the triggers, process and required response for each setting, the resource capabilities and capacity implications and what current plans are in place to support these settings.
2. have been designed to be used by those who have responsibility for an individual setting, providing a single point of access to key information on how to minimize outbreak risks and guidance on what to do if someone reports symptoms of or tests positive for COVID-19.
3. provide a transparent and consistent approach when working with PHE HPT, KCC/MC and other local partners and are intended to complement existing systems and processes for managing infectious diseases.

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

Complex Setting	Location of Action Card
Care Homes	Appendix 1
Schools & Other Educational Settings	Appendix 2
Other Health and Social Care Settings	Appendix 3
Shelter Refuges and Hostels	Appendix 4
Prisons & Detention Facilities	Appendix 5
Other Workplace Settings	Appendix 6
Transport arriving at Ports and Borders	Appendix 7
Other Transport	Appendix 8
Outdoor Settings	Appendix 9

6. Theme 4 - Testing

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

There are currently 2 types of test available for use, PCR antigen tests and antibody tests. For the purposes of the LOCP, we shall only discuss PCR antigen testing. This is the primary method used for testing, contact tracing and outbreak management in Kent and Medway.

6.1. Access to Tests

Depending on the situation and setting, there are different routes by which a person can access testing. The NHS Test & Trace (NHS T&T) system is the main route of public access to test for COVID-19 [29]. These includes home test kits, drive through regional test sites, satellite test sites, mobile testing units and dedicated local testing centres. In addition to these, there are testing systems set up by NHS hospitals and other commercial testing facilities. A summary diagram of testing is delineated in **Figure 2**

The NHS T&T locations for Kent and Medway are demand responsive. As of 24th June 2020, there were;

- Regional Test Sites in Ebbsfleet and Ashford with a site in the East of the County soon to be established
- Satellite Testing Sites on the Hoo Peninsula and at Medway Maritime Hospital NHS Foundation Trust and;
- Mobile Testing Sites available for deployment in Maidstone, Swale, Canterbury, Ashford, Dover, Folkestone and Medway. Work is ongoing to establish a site in Margate.

These will be updated, should additional testing capacity be brought on line, or future models of testing emerge. Details of current locations of the Kent and Medway NHS T&T sites are available from hscc@medway.gov.uk. Details on who is eligible for asymptomatic testing will be published on the KCC and MC websites. Further details on ensuring adequate testing access for Kent and Medway's workforce can be found in **Section 6.3**.

6.2. Testing Results and Outcomes

National guidance for the public concerning test results can be found here [30]. In the event of a negative result, no further action is needed from the NHS T&T service. However, those who have been notified to have been in contact with a person with COVID-19 should continue to isolate for the full 14 day period [31]. In the event of a positive test result, contact tracing services will be initiated. Whilst cases identified through the NHS T&T testing services will automatically be referred onto the PHE Contact Tracing and Advisory Service (CTAS), some

testing facilities, such as those at NHS trusts, may need to manually notify PHE HPT (HPU-kent@phe.gov.uk or 0344 225 3861) to ensure timely notification. Support for those that need to self-isolate can be found in **Appendix 11** with **Figure 3** outlining the Kent and Medway testing routes & notification process.

6.3. Assuring Local Testing Capacity

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

- Essential workers (including staff from Kent and Medway's local public sector agencies, national public agencies based in or assigned to Kent and Medway, suppliers of essential services/contractors, agency workers, interims or consultancies directly engaged by Kent and Medway's public agencies, and other organisations or businesses who are directly assigned to support the response). A list of essential workers can be found here [32]
- Wider resident testing as per government guidance (including care home residents and those in group living settings such as extra care, supported living and prisons in Kent and Medway)

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

KCC and MC will be required to support Pillar 1 of the national testing strategy [33]; to scale up NHS swab testing for those with a medical need and, where possible, the most critical key workers and also for outbreak management.

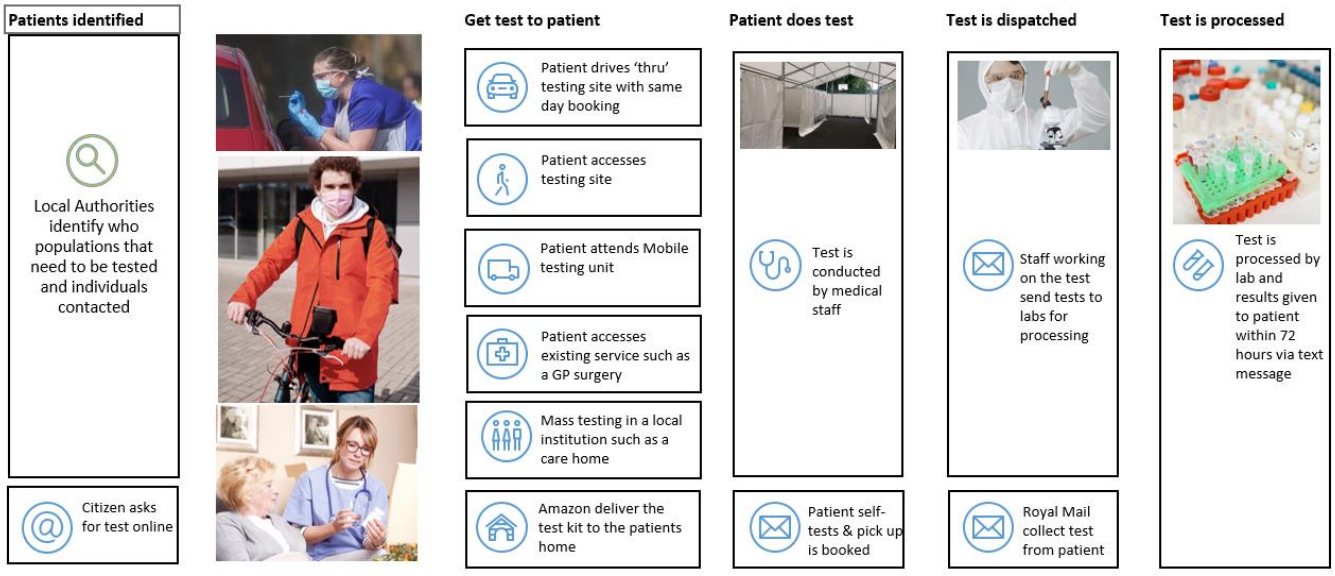

Figure 2 – Testing Delivery

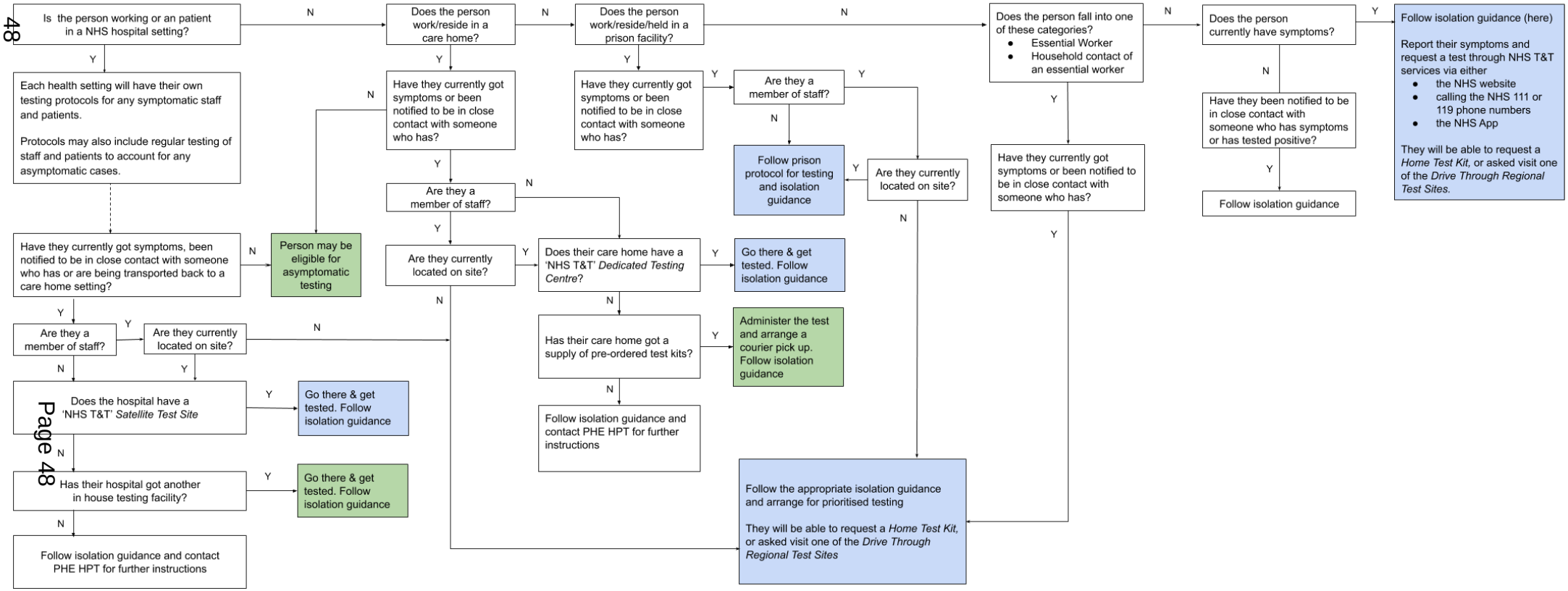

Figure 3 – Testing Access Routes

There are different routes by which a person may be able to obtain a test depending on their circumstances. BLUE boxes = testing facilities that are part of NHS Test and Trace system and results are therefore automatically fed directly through to PHE CTAS. GREEN boxes = testing facilities that need to manually notify PHE HPT of a positive test result to ensure timeliness of notification.

7. Theme 5 - Contact Tracing & Outbreak Management

7.1. Contact Tracing

The Trace component of NHS T&T is an integrated service to identify, alert and support those who need to self-isolate. It is run by the Contact Tracing and Advisory Service (CTAS) which is jointly led by NHS England and PHE and is made up of three tiers of contact tracers. The roles of each CTAS tier is outlined in **Figure 4**

All positive cases are initially referred to Tier 3 CTAS from a range of NHS T&T testing sources who will then obtain further information on details of places they have visited, and people they have been in contact with. These contacts are risk-assessed according to the type and duration of that contact. Those who are classed as 'close contacts' are contacted and provided with advice on what they should do e.g. self-isolate. Depending on the case or setting complexity, contact tracing and other health protection functions may be escalated to be handled by one of the higher CTAS tiers.

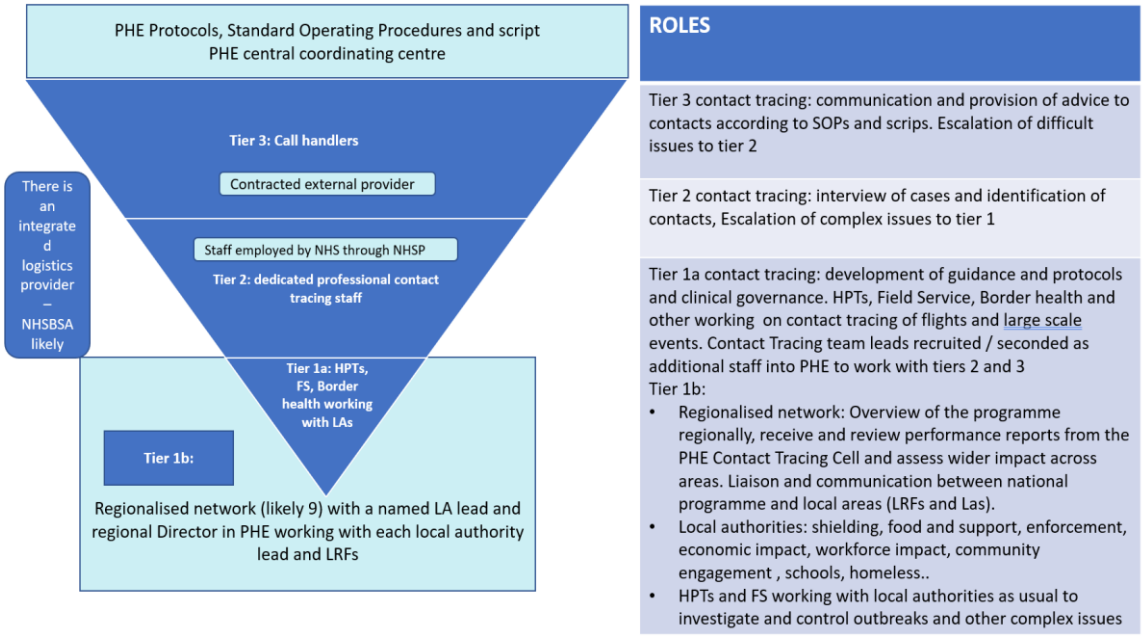

Figure 4 – Contact Tracing Advisory Service (CTAS) Contact Tracing Tiers

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

- **Tier 2** – Around 3,000 dedicated professional contact tracing staff have been recruited by NHS providers to interview cases to determine who they have been in close contact with in the two days before they became ill and since they have had symptoms. They will also handle issues escalated from Tier 3. Appropriate advice following national guidance is given to cases and their close contacts

- **Tier 1** – PHE HPT will investigate cases escalated from Tier 2. This will include those unwilling to provide information, healthcare and emergency services , complex and/or high-risk settings such as care homes, schools, prisons/places of detention, workplaces, health care facilities and transport where it hasn't been possible to identify contacts. Advice following national guidance will be given to cases, their close contacts and settings/communities as appropriate.

For the Kent and Medway localities, Tier 1 contact tracers are the PHE HPT available at HPU-kent@phe.gov.uk or 0344 225 3861. As outlined in **Section 7** and **Figure 5**, complex cases can be referred to PHE HPT contact tracers via several routes:

1. A positive case is identified by Tier 2 & 3 of NHS T&T to be complex or within a complex setting.
2. Through direct notification from a complex setting to the PHE HPT regarding either a symptomatic or confirmed positive case.

7.2. Outbreak Definition & Plan Activation

An outbreak is defined as two or more cases (suspected and/or confirmed) linked in place/time [34]. The LOCP may be triggered when there are suspected or confirmed COVID-19 outbreaks in any setting type. It should be noted that most incidents/outbreaks will be managed through business as usual measures. This plan and the relevant mechanisms will only be activated following appropriate risk assessment and discussion by the HPB. In addition, should the DPHs determine there is an urgent need, they will use appropriate measures to activate this plan. Plan initiation may also be informed by other factors, for example, central government direction in the form of information received through the JBC. Final guidance is still awaited on specific JBC trigger factors, however **Table 3** provides an overview of the initial high level JBC triggers.

7.3. Outbreak Response

In accordance with the PHE-LA Joint Management of COVID-19 Outbreaks the PHE HPT will collaborate with KCC, MC, the 12 district and borough council Environmental Health teams, the KRF SCG, Kent and Medway CCG and other key partners to deliver this response. The outbreak response will be tailored to the nuances of each setting drawing on local intelligence (see **Section 8**). In the event of an outbreak the steps (varies by setting) listed in **Table 2** will be taken. A summary overview of the outbreak response can be found in **Figure 5**

Table 2 – Steps to be Taken in Response to an Outbreak

STEP 1 – Initial Risk Assessment & Contact KCC/MC Single Point of Contact (SPOC)
After being alerted of new cases, community clusters or outbreaks, the PHE HPT will contact the relevant setting, and give infection control advice either by email or verbally. If it is decided that the setting is complex, the PHE HPT will then inform the KCC/MC SPOC by email or phone via the existing emergency planning route, depending on urgency, & have a joint discussion regarding next steps to be taken as per below.
STEP 2 – Infection Control & Response to Enquires
KCC/MC and PHE HPT will decide whether it is necessary to convene an Outbreak Control Team (OCT) who will undertake a risk assessment. The KCC/MC SPOC will also follow up with the setting's occupational health departments or other points of contact and support the affected setting on operational issues (e.g. sourcing PPE, staff capacity, removal of dead bodies & care provision). Any situation updates are fed back to PHE HPT and/or OCT.
STEP 3 - Perform Enhanced Testing & Contact Tracing
Testing of people within complex settings may be advised by the OCT. Testing will be done in collaboration between PHE and partners including mobilising existing Mobile Testing Units where necessary. KCC and MC may need to supplement testing and contact tracing efforts though NHS mutual aid, mutual aid from environmental and public health teams at district and borough councils, or external partners who have undergone training (see **Section 6.3**)
STEP 4 – Monitor Intelligence
The setting will be monitored closely using regular intelligence updates as detailed in **Section 8**
STEP 5 – Escalate Concerns & Facilitate Closures/Other Action
In the event of closures, the HPB will work with the appropriate enforcement organisation where necessary. If other control measures need to be enforced, the HPB will need to escalate to the KRF SCG and consider additional measures (see **Section 10**)

7.4. Infection Control

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

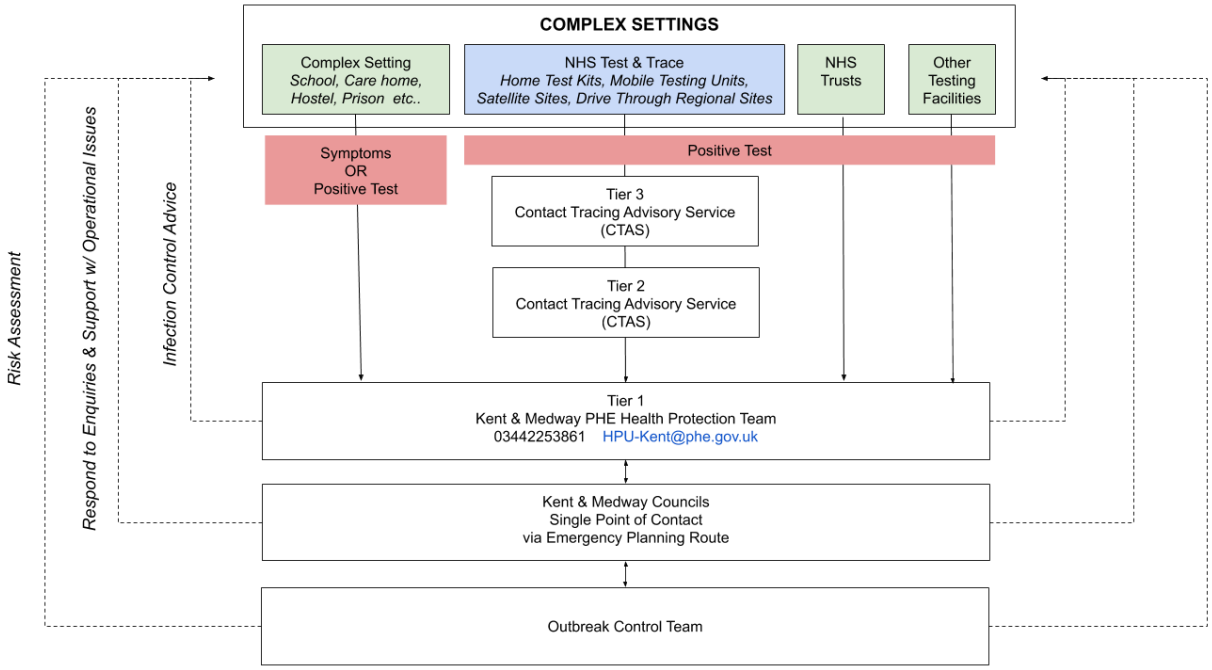

Figure 5 – Referral Routes of Cases in Complex Settings to the PHE HPT and the Required Responses. The different routes by which a positive or suspected case of COVID-19 in a complex setting can be referred to the PHE HPT. BLUE boxes = testing facilities that are part of NHS T&T system and results are therefore automatically fed through to PHE CTAS. GREEN boxes = testing facilities that may need to manually notify PHE HPT of a positive test result to ensure timeliness of notification.

8. Theme 6 - Data Integration & Analytics

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

8.1. Objectives

The available data will be used to:

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

8.2. Data Sources & Arrangements

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

8.3. Data Integration

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

The JBC *COVID-19 Outbreak Management Toolkit for England* states that according to the risk level within an area based on key metrics, there will be different guidance on how to provide Non-Pharmaceutical Interventions. To determine the risk level, both quantitative and qualitative data will be utilised with **Table 3** stating the threshold of each risk level.

This data is however not granular or timely enough to inform a system management approach to COVID-19 outbreak management. Therefore, as part of the delivery of the LOCP, the HPB are currently developing a regular situation report (SITREP) that will involve the amalgamation of several data sources. This will assist in;

1. **Early warning and surveillance** – to identify potential outbreaks / clusters that may be discernible by time, place (i.e. workplace setting, residence), location
2. **Scenario forecasting and simulation modelling** – to inform us how these outbreaks may have an impact on Kent and Medway's wider health and care systems (e.g. hospital admissions and deaths management)

8.4. Information Governance

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

However, in emergency response situations, permissions under the Civil Contingencies Act 2004 [28] requires Category 1 & 2 responders to share information with each other as they work together to perform their duties under the Act. Further guidance was provided by the *Data Protection and Sharing – Guidance for Emergency Planners and Responders (2007)*, published by the Cabinet Office. Its purpose was to inform organisations involved in the preparation for, response to, and recovery from emergencies on when they can lawfully share personal data under data protection legislation. This has subsequently been replaced by the *Data Sharing in Emergency Preparedness, Response and Recovery* guidance which, as of June 2020, is out for consultation.

In addition, the Secretary of State for Health and Social Care has issued a general notice under the Health Service Control of Patient Information Regulations 2002 [35] to support the response to COVID-19. This allows NHS Trusts, LAs, and others to process confidential patient information without consent for COVID-19 public health, surveillance, and research purposes. The notice is currently in force until 30th September 2020 and provides a temporary legal basis to allow a breach of confidentiality for COVID-19 purposes. Agencies should therefore assume they are able to adopt a proactive approach to sharing the data they need to respond to COVID-19.

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

Finally, the *Kent and Medway Information Sharing Agreement* is an agreed inter-agency information sharing protocol that is available for all organisations within Kent and Medway and includes sharing information during incident response.

Table 3 – Joint Biosecurity Centre Risk Level Thresholds

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

9. Theme 7 - Supporting Vulnerable Populations

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

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

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

Their needs may be far reaching and include:

1. enhanced communication of transmission risks and public health advice,
2. help accessing testing,
3. financial, food and/or housing support &
4. support with mental and physical healthcare.

The current list of identified vulnerable populations in Kent and Medway can be found in **Table 4**. A list of population specific action cards within the Appendix which are signposted via **Table 4**. These cards:

- outline the available support structures, services, and organisations, both locally and nationally, specific to population needs
- identify areas where arrangements may still need to be made.

In addition, details on the sources of information regarding vulnerable people can be found in the *KRF Identifying & Supporting Vulnerable People Plan* which is available from the Resilience Direct. Please refer to **Section 8** and **10** that describe the data analytics and communications strategies specific to these populations.

Table 4 – List of Vulnerable Populations and the Location of their COVID-19 Action Cards

Vulnerable Population	Location of Action Card
Clinically Extremely Vulnerable People (Shielders)	Appendix 10
Those who are Self Isolating	Appendix 11
Black, Asian and Minority Ethnic (BAME) Communities	Appendix 12
Sex Workers	Appendix 13
Substance Misuse	Appendix 14
Homeless	Appendix 15
Learning Disabilities	Appendix 16
Travelling & Migrating Communities	Appendix 17
Asylum Seekers	Appendix 18

10. Theme 8 - Communication & Engagement Strategy

To ensure the impact of COVID-19 in Kent and Medway is minimised, it is crucial that there are clear communication lines between key stakeholders and the general public. This section outlines the Kent and Medway multi-agency communications and engagement strategy.

There are already several well-established internal communication channels between working groups and committees involved in Kent and Medway's COVID-19 planning and response. In the event of an outbreak;

1. PHE HPT will initiate a joint discussion with the KCC/MC SPOC, as described in **Section 7.3**
2. Together they will decide what response is required, including whether to convene an OCT, and communicate this to the KRF SCG.
3. If the KRF SCG is sitting, then the KCC/MC SPOC and/or the PHE HPT will contact the Chair of the KRF SCG to advise them that they are activating this plan. If the KRF SCG isn't sitting, then the KCC/MC SPOC and/or the PHE HPT will contact the KCC Duty Emergency Planning Officer (DEPO) who will activate the KRF SCG via the procedures outlined in the *KRF Pan Kent Strategic Emergency Response Framework*.
4. The KRF SCG will ensure all activities, including COVID-19 response updates, are then communicated to local, regional and national partners as well as other key stakeholders via the KRF - Media & Communications Cell.
5. If the DPHs and LA CEOs decide an operational response is required, the KRF SCG will communicate this to the KRF TCG who will coordinate the response as detailed in the *KRF Pan Kent Strategic Emergency Response Framework*. Communication to the KRF TCG may relate to LOCP activities including; (1) implementation of local outbreak control measures such as a local lockdown, (2) facilitation of closures & (3) quarantine.

Outlined below are specific communications components for the; (1) general public (2) complex settings (read in conjunction with **Section 5 & 7**) & (3) voluntary organisations (read in conjunction with **Section 9**)

10.1. The Public

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

This comprises;

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

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

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

The KRF SCG will use a range of methods to ensure information is distributed in a timely manner. They will work together with the KRF COVID-19 Vulnerable People and Communities Cell to ensure they reach vulnerable populations. They will also leverage existing relationships with community and faith leaders alongside digital engagement tactics such as targeted advertisement for areas with high infection rates using social media.

In addition, the LOEB will play an essential role in ensuring a two-way process of communication. They will empower the public and businesses to share the challenges and opportunities they have experienced through implementing COVID-19 measures, allowing for learning.

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

10.2. Complex Settings

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

10.3. Voluntary and Community Sectors

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

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

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Appendix 1 – Care Homes

Including

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

Objective

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

Context:

There are 613 CQC registered adult care homes in Kent and Medway.

The ownership types include:

- 496 privately owned
- 104 voluntary/non-for-profit
- 1 NHS service
- 12 local authority owned

The type of care homes includes:

- 489 Residential homes (care only)
- 124 Nursing homes (care home with nursing)

What's already in place:

All partners within the HSCC have worked closely with several partner organisations to implement a package of measures to support care homes in Kent and Medway to prevent and respond to outbreaks, including:

- PHE has an outbreak management plan for use in care homes to support in identifying and escalating new suspected cases of COVID-19
- British Geriatrics Society has released a good practice guide for COVID-19: Managing the COVID-19 pandemic in care homes for older people
- The NHS has offered training in infection control for care home staff
- The NHS has committed that all care homes will be supported via primary care and community support
- The UK Government is offering all care homes a support package
- Care homes with residents who have a certain degree of frailty have access to 'extra-care schemes' support

What else will need to be put in place:

- Testing arrangements for individuals prior to a new care home admission or transfer to another care setting (excluding hospital) still need to be put in place.
- A children homes SOP is currently in development which incorporates established processes and procedures to ensure staff are aware of how to access testing for symptomatic children and how to respond to an outbreak.

Local outbreak triggers & process:

- A single new case with symptoms consistent with COVID-19 infection, likely to be due to spread of the virus within the care home.
- Assessment of resident cases when considering any potential outbreak should also include symptomatic cases who have either been transferred from the facility to hospital as a result of infection or a suspected COVID-19 individual who has died within the same time period. They will then be tested again upon discharge from the acute setting.
- PHE HPT should conduct a situation assessment. Investigations should include testing as per the request or advice of the PHE HPT, clinicians or GP that has attended and reviewed the case.
- If there is a confirmed outbreak after conducting investigations, they should complete the Immediate Infection Control Checklist and implement the COVID-19 Daily Actions Checklist by PHE HPT.
- PHE HPT will consider the outbreak's spread and severity, current control measures, the wider context and will jointly consider with KCC/MC the need for an OCT.
- Once the outbreak is confirmed over, if an area is closed to admissions, the criteria for reopening as a minimum should be; (1) no new symptomatic cases for a period of 14 days, (2) existing cases to be isolated/cohorted and symptoms should be resolving, and (3) there should be sufficient staff to enable the facility to operate safely.

Resource capabilities and capacity implications:

Staffing

- Additional infection prevention and control training and support for care homes with outbreaks
- Ongoing provision of PPE until care homes can source PPE through normal supply routes or the PPE portal for small care homes (less than 24 beds)

Links to additional information:

- Coronavirus (COVID-19): Adult Social Care Guidance
- Apply for Coronavirus Tests for a Care Home
- BGS COVID-19: Managing the COVID-19 pandemic in care homes for older people

Appendix 2 – Schools, Early Years & Other Educational Settings

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

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

Context:

In Kent and Medway, there are:

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

What's already in place:

As schools start to partially reopen, procedures have been put in place to implement national guidance on effective protective measures to reduce risks to staff and pupils including

- From week commencing 1 June, primary schools have welcomed back children in nursery, reception, year 1 and year 6, alongside priority groups. From 15th June, secondary schools, sixth form and further education colleges will offer some face-to-face support to supplement remote education of year 10, year 12, and 16 to 19 students who are due to take key exams next year, alongside full time provision they are offering to priority groups
- Nurseries and other early years providers, including childminders, have begun welcoming back all children.
- Special schools, special post-16 institutions and hospital schools will work towards a phased return of more children and young people without a focus on specific year groups.
- PHE has an outbreak management plan for use in schools to support in identifying and escalating new suspected cases of COVID-19
- Priority access to testing is available to all essential workers and their households. This includes anyone involved in education, childcare or social work - including both public and voluntary sector workers, as well as foster carers. Essential workers, and those who live with them, can book tests directly online.
- In Medway, Public Health support around COVID-19 related issues is given to schools via the weekly Head Teachers reference group

What else will need to be put in place:

- PHE are currently finalising several draft SOPs for test and trace of single cases and outbreaks in educational settings including childminders, nurseries & special schools
- KCC and MC are developing a SOP which will incorporate established processes and procedures to ensure schools, parents, county councils, and healthcare colleagues are aware of how to access testing for symptomatic people and how to respond to an outbreak.

Local outbreak triggers & process:

This is considered a complex setting under the remit of Tier 1 PHE HPT contact tracers. Therefore, in the event that one of their staff or residents shows symptoms or has received a positive test result, PHE HPT should be contacted immediately.

An outbreak in an educational setting is suspected if there is either:

- Two or more confirmed cases of COVID-19 among pupils or staff in a setting within 14 days or;
- An increase in pupil absence rates, in a setting, due to suspected or confirmed cases of COVID-19

If a COVID-19 outbreak is suspected in an educational setting, the PHE HPT will be immediately contacted. The PHE HPT will undertake a risk assessment and conduct a rapid investigation and advise on the most appropriate action to take.

Depending on the risk assessment outcome, the PHE HPT and KCC/MC may establish an OCT to help manage the situation. The OCT will lead the Public Health response and investigations and put appropriate interventions in place. This may include;

- Cleaning in the workplace for cleaning and waste management;
- Ensure parents and staff are aware of what has happened, and the actions being taken;
- Closure: this is rarely needed to control an outbreak and should only be done following advice from the PHE HPT and discussion with KCC/MC and Regional Department of Education REACT team

When a child, young person or staff member develops symptoms compatible with COVID-19, they should be sent home and advised to self-isolate for 7 days and arranged to be tested. Schools are to obtain PPE from procurement lines and refer to Education Department for government PPE support prior to requesting KRF support. Where the child, young person or staff member tests negative, they can return to their setting and their household members can end their self-isolation.

Resource capabilities and capacity implications:

- A KCC/MC SOP on supporting when an outbreak among staff has been identified and control measures need to be implemented

Links to additional information:

- Coronavirus (COVID-19): guidance for schools and other educational settings
- Actions for education and childcare settings to prepare for wider opening from 1 June 2020
- Coronavirus (COVID-19): implementing protective measures in education and childcare settings

- Safe working in education, childcare and children's social care settings, including the use of personal protective equipment (PPE)
- COVID-19: cleaning in non-healthcare settings
- Coronavirus: travel guidance for educational settings
- Supporting children and young people with SEND as schools and colleges prepare for wider opening
- Planning guide for early years and childcare settings
- Actions for early years and childcare providers during the coronavirus outbreak

Appendix 3 – Health and Social Care Settings

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

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

Context:

In Kent and Medway, there are:

- 382 GPs
- 342 Pharmacies
- 429 Dentists
- 24 Hospitals
- 1 Mental Health Trust
- 2 Community Health Trusts
- 4 Acute Trusts (including 3 Foundation Trusts)
- 1 Ambulance Service

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

What's already in place:

- PHE has an outbreak management plan for use in community and primary care for identifying and escalating new suspected cases of COVID-19
- All NHS Trusts have outbreak management plans to support in identifying and escalating new suspected cases of COVID-19
- SOP for GP surgery is released by the NHS and Royal College of General Practitioners guidance for GPs are provided on their website.
- SOP for Community Pharmacy is released by the NHS
- SOP for dental practice on urgent dental care and phased transition are released by the NHS.
- SOP for community health services is released by the NHS
- Legal guidance for mental health, learning disabilities and specialised commissioned mental health services is released by the NHS.
- Information for ambulance services can be found on the designated page of the NHS website.
- Infection control, PPE, clinical waste and environmental decontamination guidance are available on the designated page of the NHS website.

What else will need to be put in place:

General Practices and Walk-in Centres

- Antibody testing for staff and patients

Community Pharmacy

- Funding to support a locally commissioned service for delivery of medicines (in the event of the national pandemic pharmacy delivery service having ended)

- Consider prioritisation of pharmacy staff within key services e.g. school places, access to other essential services

Mental Health and Community Trusts

- A KCC/MC SOP on supporting the Mental Health and Community Trusts when an outbreak in the workplace or homes that they care for has been identified and control measures need to be implemented

Ambulance Services

- A KCC/MC SOP on supporting the ambulance services when an outbreak among staff has been identified and control measures need to be implemented

Local outbreak triggers & process:

- If multiple cases of COVID-19 (suspected or confirmed) are linked to exposure within a care setting, PHE will consider the severity and spread of the outbreak, current control measures, the wider context and will jointly consider with the NHS and LA the need for an OCT.

Resource capabilities and capacity implications:

- Vehicles with aerosol generating procedures need to follow a thorough decontamination procedure. An appropriate auditing procedure should be in place to ensure decontamination is being conducted accurately in ambulances.

Links to additional information:

- Primary Care COVID19 guidance
- SOP for GP surgery
- RCGP's website.
- SOP for Community Pharmacy
- SOP for urgent dental care & phased transition for dental services
- SOP for community health services
- Legal guidance for mental health, learning disabilities and specialised commissioned mental health services

Appendix 4 – Shelters, Refuges, Hostels & Other Temporary Accommodation

Including: Homeless shelters, domestic abuse refuges, caravan parks, hotels, and any other facilities providing temporary accommodation

Objective: To closely monitor cases of COVID-19 amongst homeless, vulnerable populations, survivors of domestic abuse/their children and any others living in temporary accommodation, ensuring any outbreaks are managed quickly and efficiently.

Context:

- The homeless shelters/accommodation sector include temporary accommodation hostels, B&B, housing association, local authority, private sector properties leased by LAs or Housing Associations and "other" types including private landlords.
- The domestic abuse refuges in Kent and Medway are offered by Domestic Abuse Support Services which includes emergency safe accommodation, where survivors of domestic abuse and their children are housed.

What's already in place:

- PHE has an outbreak management plan for use in sites of multiple occupancy such as hotels/hostels to be used by housing managers across Kent and Medway to support in identifying and escalating new suspected cases of COVID-19

What else will need to be put in place:

- As we start to prepare for recovery and transition those in temporary safe accommodations into longer term housing, there is a need for testing to be extended to those who are asymptomatic. There may resistance on the part of landlords/ladies to house vulnerable populations without a negative COVID-19 test. An SOP must be developed by KCC and MC to inform housing managers of alternative solutions to finding appropriate accommodation for this population in case challenges are encountered.
- An OCT may be required for current emergency accommodation sites. Issues may arise regarding sharing confidential health information with housing managers.

Local outbreak triggers & process:

- This is considered a complex setting that is under the remit of Tier 1 PHE HPT contact tracers. Therefore, in the event that one of their staff or residents shows symptom or has received a positive test result, PHE HPT should be contacted immediately.
- If a COVID-19 outbreak is suspected, the PHE HPT and KCC/MC will undertake a risk assessment and conduct a rapid investigation and advise on the most appropriate action to take. Depending on the risk assessment outcome, the PHE HPT and KCC/MC may establish an OCT to help manage the situation. The OCT will lead the Public Health response and investigations and put appropriate interventions in place. This may include;
  - PPE and face coverings;
  - Handwashing and respiratory hygiene or hand sanitisers
  - Social distancing;
  - Cleaning and waste management to maintain hygiene;
  - Workforce management;

• In the case of cramped temporary housing accommodation which does not have space for social distancing and hand washing facilities may be shared, other measures may have to be taken as specified by the OCT
Resource capabilities and capacity implications:
Links to additional information: • Working safely during coronavirus • COVID-19: guidance for domestic abuse safe accommodation provision • COVID-19: cleaning in non-healthcare settings • NHS test and trace: workplace guidance • COVID-19 Advice for Accommodation Providers • Staying alert and safe (social distancing) • COVID-19: guidance for hostel or day centre providers of services for people experiencing rough sleeping

Appendix 5 – Prisons & Detention Facilities

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

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

Context:

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

What's already in place:

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

What else will need to be put in place:

Local outbreak triggers & process:

- If a COVID-19 outbreak is suspected in outdoor community settings, the PHE HPT and KCC/MC will undertake a risk assessment and conduct a rapid investigation and advise on the most appropriate action to take. Depending on the risk assessment outcome, the PHE HPT and KCC/MC may establish an OCT to help manage the situation.
- The OCT will lead the Public Health response and investigations and put appropriate interventions in place. This may include;
    - PPE and face coverings;
    - Handwashing and respiratory hygiene;
    - Social distancing;
    - Cleaning and waste management to maintain hygiene;

- Workforce management;
- Bespoke advice for the particular circumstance in each case.
- Cessation of all social visits

- All detainees with suspected or confirmed COVID-19 transported and managed according to the transportation and transfer guidance.
- Any staff member showing symptoms should be sent home immediately and they must follow Government guidance

Resource capabilities and capacity implications:

- Prison officers to enforce control measures and escort and transport detainees who need to be transferred
- Healthcare staff to test both detainees and prison staff

Links to additional information:

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

Appendix 6 – Other Workplace Settings

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

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

Context:

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

In addition, in Kent and Medway,

- There are 4 county & family courts
- There are 12 leisure centres, many independent gyms and sports clubs.

What's already in place:

The NHS T&T service supplements risk mitigation measures taken by employers by identifying people who have had close recent contact with someone who has tested positive for COVID-19 and advising them to self-isolate, however, it does not change the existing guidance about working from home wherever possible. Employers should continue to follow the guidelines to prevent the spread of COVID-19 to reduce risk. Upon detecting a suspected or confirmed case of COVID-19 employers should immediately inform the PHE HPT. Employers must;

- Carry out a COVID-19 risk assessment following the Health and Safety Executive guidance;
- Develop cleaning, handwashing and hygiene procedures in the workplace;
- Help employees to work from home; discuss home working arrangements and ensure they have the right equipment for remote working;
- Maintain 2m social distancing, where possible; put up signs to remind workers and visitors of social distancing guidance and use tape to mark 2m distance between workspaces where appropriate;

- Where people cannot be 2m apart, manage transmission risk by using screens or barriers to separate people from each other and staggering arrival and departure times;
- When necessary, consider methods to reduce frequency of deliveries
- A number of practical safety measures including new signs, street markings and temporary barriers to ensure Kent and Medway's high streets are ready for when businesses are able to open and trade safely.

What else will need to be put in place:

- A communications plan to the business sector on how to provide national guidance on preventing outbreaks in workplaces and accessing testing;
- A KCC/MC SOP on supporting the business sector when an outbreak in the workplace has been identified and control measures need to be implemented

Local outbreak triggers & process:

- If a COVID-19 outbreak is suspected in workplace settings, the PHE HPT and KCC/MC will undertake a risk assessment and conduct a rapid investigation and advise on the most appropriate action to take. Depending on the risk assessment outcome, the PHE HPT and KCC/MC may establish an OCT to help manage the situation. The OCT will lead the Public Health response and investigations and put appropriate interventions in place. This may include;
  - PPE and face coverings;
  - Handwashing and respiratory hygiene;
  - Social distancing;
  - Cleaning and waste management to maintain hygiene;
  - Workforce management;
  - Management of customers, visitors and contractors;
  - Control of inbound and outbound goods;
  - Self-isolation
- Symptomatic individuals should access testing in line with current advice. Advice and information provided through contact tracing should be followed by all symptomatic individuals and their contacts.

Resource capabilities and capacity implications:

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

Links to additional information:

- NHS test and trace: workplace guidance
- Working safely during coronavirus
- Guidance on prioritising waste collection services during coronavirus (COVID-19) pandemic
- Guidance for Managing Household Waste and Recycling Centres (HWRCs) in England during the coronavirus (COVID-19) pandemic
- Information on the water industry and Coronavirus (COVID-19)
- Guidance for food businesses during COVID-19

- Cleaning in a non-healthcare setting
- Need FSA guidance for food businesses on COVID-19
- Guidance for restaurants offering takeaway or delivery
- Food Handlers - Fitness to work
- Guidance for working in, visiting or delivering to other people's homes
- COVID-19: investigation and initial clinical management of possible cases
- Find your local Health Protection Team in England

Appendix 7 – Transport Arriving via Trains, Ports & Borders

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

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

Context:

In Kent and Medway there are 4 ports and a harbour.

- Port of Whitstable: fishing, small commercial
- Port of Ramsgate: fishing, leisure, lifeboat
- Port of Dover: ferry, leisure, commercial/cargo, cruise terminals, lifeboat
- Folkestone: difficult, largely derelict

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

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

Buses and cars arriving in Folkestone from France via the Eurotunnel

What's already in place:

- UK travel quarantine rules have come into effect requiring all people arriving in the UK to self-isolate for 14 days. People arriving by plane, ferry or train – including UK nationals – will have to provide an address where they will self-isolate and face fines of up to £1,000 if they breach the rules.
- Check points have been set up on roads in line with KCC Brexit preparedness plans

What else will need to be put in place:

- Provision of support for food and medical supplies for the 14 days self-isolation period in the event of an outbreak on a cruise ship
- Driver welfare provisions

Local outbreak triggers & process:

- For UK residents, self-isolating in normal place of residence is unlikely to result in outbreaks.
- For visitors, self-isolation in commercial accommodation such as hotels etc has the potential to result in outbreaks in commercial premises. PHE HPT will consider the severity and spread of the outbreak, current control measures, the wider context and will jointly consider with the KCC/MC the need for an OCT

Resource capabilities and capacity implications:

- Provision of support for food and medical supplies during the 14 days self-isolation period

Links to additional information:

- COVID-19: Shipping and seaports guidance
- Arrangements for driver welfare and hours of work during the coronavirus outbreak
- Border control

Appendix 8 – Other Transport

Including: Bus, Taxi, Walking & Cycling, Private cars, Car sharing
Objective: To identify and eliminate all cases of COVID-19 in any other method of transport to protect employees, visitors and customers during the gradual restarting of the local economy and movement of the population.
Context: In Kent and Medway, there are: • 199 private car hire companies • 18 coach service operators
What's already in place: • It is currently compulsory to wear a face covering on all public transport including private hire cars. • Car sharing or public transport should be discouraged as possible.
What else will need to be put in place: • A mobile app or similar, to contact trace all public transport contacts
Local outbreak triggers & process: • Public transport associated with an area where there is a localised community outbreak will need to be considered by the OCT • However, this can only become a reality when the mobile phone app is in place nationally, the majority of the public use it, and the government decides how to respond to increased incidence of COVID-19 associated with a particular transport route/hub.
Resource capabilities and capacity implications:
Links to additional information: • Coronavirus (COVID-19): safer travel guidance for passengers • Bus Operator Directory • Private car hire Directory

Appendix 9 – Outdoor Settings

Including: Parks and green spaces, outdoor gyms, entertainment resorts, tourist attractions, beaches, playgrounds, pools, funeral grounds, zoos
Objective: To ensure compliance to social distancing measures to manage transmission risks and deaths from COVID-19 in outdoor community settings in Kent and Medway
Context: Public parks and green spaces. Green spaces will typically include parks, recreation grounds, publicly accessible playing fields, public open spaces associated with housing developments and public burial grounds. These areas are likely to be enclosed by a variety of boundaries with 'pinch points' at entrances.
What's already in place: • In England, Kent and Medway residents can leave their home to exercise and spend time outdoors for recreation, sports and other activities with their household or support bubble or in groups of up to 6 people from another household or support bubble • Currently overnight stay is not allowed (with some exceptions) with campsites and caravan parks closed. • All staffs should wear face masks if social distancing is not feasible. • PHE released a guidance for providers of outdoor facilities on the phased return of sport and recreation in England
What else will need to be put in place:
Local outbreak triggers & process: • Symptomatic individuals should access testing in line with current advice. Advice and information provided through contact tracing should be followed by all symptomatic individuals and their contacts.
Resource capabilities and capacity implications: • Staffing to monitor compliance and impose social distancing measures in outdoor community settings
Links to additional information: • Working safely during coronavirus • Coronavirus (COVID-19): safer public places - urban centres and green spaces • Coronavirus – guidance on accessing green spaces safely • Cleaning in non-healthcare settings • NHS test and trace: workplace guidance • Guidance for people who work in or run outdoor working environments

Appendix 10 – Clinically Extremely Vulnerable (Shielders)

Objective:
The objective is to support clinically extremely vulnerable people whilst shielding at home

Context:
Emerging research suggests that certain groups of people are at enhanced risk of developing severe COVID-19 if they contract the virus, based on their underlying comorbidities. The government has recognised that some people are at higher risk of severe illness from SARS-CoV-2 (clinically vulnerable people) and a smaller minority with specific serious medical conditions are at even higher risk of severe illness (clinically extremely vulnerable). Clinically extremely vulnerable people include individuals with the conditions outlined in the guidance below and additional individuals who have been identified by their treating primary or secondary care physician based on their medical history and circumstance.

On March 23rd 2020, clinically vulnerable people were advised to stay at home as much as possible, and to minimise social contact when they went out. Clinically extremely vulnerable people were asked to shield at home (shielders).

On 1st June 2020, this advisory guidance was relaxed, but not lifted, in order to allow clinically extremely vulnerable people to leave their homes and meet with one other person. It is recognised, however, that some individuals may not feel comfortable leaving their homes during this current period. There are, therefore, still significant restrictions placed upon these individuals which will continue to impact upon their daily lives.

What's already in place:
Government coronavirus support service: shielders register here or by calling the dedicated helpline on 08000288327, even if they do not currently need help. This provides (1) weekly box of basic food supplies; (2) priority access for supermarket deliveries, and (3) help for meeting basic care needs

Local general support

- Kent Together is working with system partners to organise help for vulnerable people: register here or at 0300419292 (24/7 helpline)
- Red Zebra in Kent is providing social prescribing, emergency food parcels and support isolated individuals
- NHS Volunteer Responders can help with shopping, collecting medications, and offer a friendly chat
- There are a number of organisations in Medway that are offering support with shopping, essential tasks and befriending. These include The Salvation Army, The Diocese of Rochester and WHOO Cares.

Food:

- Support from family, friends and neighbours (includes provision of culturally familiar foods)

- Mutual aid groups
- Community food projects
- Food parcels https://www.helpingthehomeless.org.uk/COVID-19-work
- Medway vulnerable people support hub and voluntary and community sector (VCS) assisting with shopping pickup and delivery (e.g. Walderslade Together, Salvation Army Gillingham, Second Chance Charity)
- Essential emergency food project for shielders in Medway

Medications:

- Pharmacies in England have been contracted to deliver medications to shielders as part of the community pharmacy pandemic delivery service
- Some VCS organisations are picking up prescriptions on behalf of vulnerable people (e.g. Salvation Army Gillingham, WHOO cares)

Mental health:

- Helplines: national Samaritans 24/7; Kent and Medway NHS and Social Care Partnership Trust 24/7 (0300 222 0123)
- GP support
- Free, accessible services open to self-referral for Kent and Medway can be found here
- If the resident is an existing patient, the treating secondary care mental health team

Social isolation and loneliness: likely to have increased prevalence amongst shielders

- Telephone befriending, such as by Medway Voluntary Action, CarersFIRST, and AgeUK Medway

Financial hardship: shielders who now have reduced or no income streams

- Medway council tax reduction scheme

What else will need to be put in place:

Physical health:

- Health promotion activity/campaign to reduce risk of non-communicable disease (cardiovascular etc) from physical inactivity in shielders
- Communications to encourage shielders to seek medical attention if needed during the pandemic – some may be reluctant to attend hospital due to myths and fears around COVID-19.

Mental health:

- Shielding is likely to negatively impact upon individuals' mental health, exacerbating existing diagnoses, and precipitating new issues
- Need to address the gap in mental health services to both Community Support Hubs and housing services, particularly from secondary care

Social isolation and loneliness:

• Local offers which minimise or mitigate against digital exclusion and language barriers **Financial hardship**: • It is important that the council does all it can to support these individuals. This may be through payment holidays (for rent where the council is the landlord, council tax payments), or hardship grants if available.
Resource capabilities and capacity implications:
Links to additional information: Updated national guidance for clinically extremely vulnerable people who have been asked to shield is outlined here.

Appendix 11 – Those Who are Self-Isolating

Objective:
The objective is to support people in isolation including those who may be shielding or self-isolating

Context:
In the event someone becomes symptomatic or is informed by NHS T&T contact tracing services that they have been in contact with someone who has tested positive with COVID-19, they will need to immediately self-isolate for a period of 7 or 14 days, respectively. Depending on the context, their household contacts may also need to immediately self-isolate. Given that the request for self-isolation will be sudden, it is important that the impact on these individuals is considered.

Many residents will have sufficient supplies and networks to draw upon to last them the duration of isolation. However, some residents will not. They should have rapid access to sufficient resources, such as food and medications, to see them through self-isolation, to ensure maximum compliance.

What's already in place:

Local general support

- Kent Together is working with system partners to organise help for vulnerable people: register here or at 0300419292 (24/7 helpline)
- Red Zebra in Kent provide social prescribing, emergency food parcels and support isolated individuals
- NHS Volunteer Responders can help with shopping, collecting medications, and offer a friendly chat

Food:

- Support from family, friends and neighbours – can provide more culturally familiar foods
- Mutual aid groups
- Community food projects
- Medway vulnerable people support hub and VCS - assisting with shopping pickup and delivery (e.g. Walderslade Together, Salvation Army Gillingham, Second Chance Charity)
- Essential emergency food project for shielders in Medway

Medications:

- Some VCS organisations are picking up prescriptions on behalf of vulnerable people (e.g. Salvation Army Gillingham, WHOO cares)

Mental health:

- Helplines: national Samaritans 24/7; Kent and Medway NHS and Social Care Partnership Trust 24/7 (0300 222 0123)
- GP support

- Free, accessible services open to self-referral for Kent and Medway can be found here
- Treating secondary care mental health team if resident is an existing patient

Social isolation and loneliness: likely to have increased in prevalence amongst shielders

- Telephone befriending, such as by Medway Voluntary Action, CarersFIRST, and AgeUK Medway

What else will need to be put in place:

Medication

- Pharmacies in England have been contracted to deliver medications to shielders as part of the community pharmacy pandemic delivery service, and may be able to extend this to those self-isolating (need to ensure robust local arrangements)

Childcare

- Plans for emergency childcare arrangements if no parent/guardian is fit to care for a child – will likely involve children's social services

Data on demand for help amongst self-isolators

- Regular analysis of NHS T&T data may help identify trends in numbers of residents being asked to self-isolate, and help pre-empt surges in need amongst them

Mental health

- Need to address the gap in mental health services to both Community Support Hubs and Housing services, particularly from secondary care

Resource capabilities and capacity implications:

As the NHS T&T system develops, it is likely that more Kent residents will be required to self-isolate. This could overwhelm the existing infrastructure for support with food shopping and collecting medications.

Links to additional information:

Appendix 12 – Black, Asian, and Minority Ethnic (BAME) Communities

Objective:

The objective is to reduce new cases, and mitigate against the disproportionate impact, of COVID-19 amongst BAME communities.

Context:

Recent evidence reviews consistently show that BAME individuals are overrepresented in those who have died from COVID-19 [17]. In Kent, 6.6% are of BAME origin with the largest single BAME group represented by Indian ethnicity 1.2% of the total population. In Medway, 10.4% of the total population identified as BAME with Asian Indian accounting for the largest proportion with 2.7% (see section 2). PHE have also published a report on the impact of COVID-19 on BAME communities, following stakeholder engagement, with clear recommendations for future action.

What's already in place:

- BAME networks: Kent and Medway NHS and Social Care Partnership Trust BAME network and Medway Diversity Forum. These are trusted BAME networks, which will be important in both helping shape future work around BAME populations, and also help to recruit residents for engagement

What else will need to be put in place:

Data

- Comprehensive and quality ethnicity data collection and recording for local COVID-19 tests to allow better monitoring of disparities in those being diagnosed with COVID-19.

Rapid needs assessments

- These should be undertaken for local BAME populations, incorporating proactive participatory resident engagement to understand local and personal perspectives. Actions which arise from these should be co-produced with BAME residents. Engagement should be a continued process, instead of a one-off exercise.
- Existing, trusted BAME networks, such as the Kent and Medway NHS and Social Care Partnership Trust BAME network and Medway Diversity Forum, may be helpful to recruit participants for engagement.

Culturally competent individualised occupational risk assessments

- Increasing numbers of employers, including the Greater London Authority (Transport for London, The Metropolitan Police, London Fire Brigade) and the NHS, are conducting enhanced risk assessments for BAME staff to mitigate the disproportionate effect of COVID-19 on BAME individuals. Although this may be harder to enforce across all employers in Kent and Medway, both councils can lead by example to ensure that BAME council employees, particularly public-facing workers, are risk assessed to see if additional precautions can be implemented to reduce the risk of exposure to, and acquisition of, COVID-19.

Culturally competent communications:

- Culturally sensitive comms which use culturally specific imagery and language. These must be provided in multiple languages to ensure accessibility for all residents.
- Communications plans should be developed in tandem with community and faith leaders to increase reach, mitigate the fear and stigma in communities arising from headlines around BAME and COVID-19, and to encourage communities to take full advantage of interventions (e.g. contact tracing, antibody testing etc)

Equitable access to education:

- BAME families may be reluctant to send their children back to school, for fear of increasing the risk of contracting SARS-CoV-2. Engagement with local BAME residents is needed to understand if this is an issue, and to what extent.
- Families who do not send their children back to school should be supported to ensure the children receive equitable access to education and are not disadvantaged. In partnership with local schools, this may include supplying tablets/laptops to families who cannot afford them, so that they can maintain schooling virtually.

Resource capabilities and capacity implications:

Staffing to rapidly mobilise the above actions

Links to additional information:

PHE report on the impact of COVID-19 on BAME communities

PHE report on the disparities in risks and outcomes of COVID-19

Doctors of the World have published translated COVID-19 advice in 60 languages (written and audio), available here

Appendix 13 – Sex Workers

Objective:
The objective is to support sex workers during COVID-19, including those who may need to shield or self-isolate

Context:
Sex workers are amongst the most marginalised groups in society, and will likely have been, and continue to be, disproportionately impacted by COVID-19

The social distancing measures enforced during the pandemic will have significantly disrupted their ability to generate income. Sex work between consenting adults is legal in the UK (although associated activities, such as soliciting, are illegal). There is therefore some financial assistance available, in the form of the government's coronavirus job retention scheme for furloughed workers, but only if they were already registered as self-employed. It is unclear to what extent sex workers will benefit financially from this scheme.

Some sex workers may have been unable to stop 'in-person services' because of their financial difficulty, which will expose them to greater risk of contracting SARS-CoV-2. They may also act as vectors of infection. Others still may be impacted by the changes made by healthcare services, which may reduce accessibility to protective equipment (condoms, dental dams, femidoms etc) and timely consultation and investigations for sexually transmitted infections.

Sex workers are likely to experience or have experienced stigma and/or exploitation. It is important to recognise why contact tracing as part of the NHS T&T system may require particular sensitivity (in addition to the confidentiality afforded to all contacted) when it concerns a sex worker. This will be vital in securing their continued cooperation.

What's already in place:

General support

- National: Beyond the Streets
- In Medway: Caring Hands in the community (homeless and marginalised people); Street Pastors all offer support to sex workers. One Big Family also support sex workers in Medway.
- Specific needs that emerge from financial hardships, such as food and accommodation, may be addressed through joined approaches with VCS organisations (emergency food parcels, regular food deliveries) and other LA workstreams (homelessness)

Protective equipment:

- Continue to make protective equipment freely available (condoms, dental dams, femidoms etc) e.g. METRO charity offering free condoms, testing and sexual health advice and support in Kent and Medway for those aged 13-25y

Access to healthcare:

- Existing sexual health clinics are being kept open, as far as possible, to allow sex workers to maintain good sexual health e.g. Clover Street (Medway sexual health hub) which still

accepts new attendances, but on an appointment-only basis or through telephone triage to access a virtual or clinic appointment
What else will need to be put in place: **Financial hardship schemes**: • As above, which may obviate the need to continue in-person sex work during the pandemic **Access to healthcare:** • Encouraging STI testing particularly throughout the COVID-19 pandemic e.g. the Breaking the Chain: Time to test campaign
Resource capabilities and capacity implications:
Links to additional information: Test now stop HIV campaign website

Appendix 14 – Substance Misuse

Objective:

The objective is to support substance misusers during COVID-19, including those who may need to shield or self-isolate

Context:

Substance misusers can face additional risks compared to the general population, associated with their substance misuse behaviours, environments and/or care. The rising drug misuse death rates in England over recent years has largely been attributed to the ageing opiate-misusing population, many of whom have long drug careers and high physical morbidity. Moreover, recent literature suggests that people who use drugs are disproportionately affected by chronic medical conditions, such as COPD and cardiovascular disease. This means that they are also likely to be more vulnerable to severe COVID-19.

The government's guidance for commissioners and service providers of substance misuse services outlines the key expectations of these specialist services during the COVID-19 pandemic. Of note:

- substance misuse services should stay open for existing and new service users
- changes will need to be made to medication prescribing and dispensing in accordance with rules on social distancing
- harm reduction measures, such as naloxone, thiamine, needle exchange, and e-cigarettes, should continue and be increased if possible

What's already in place:

- Alternative substance misuse service arrangements: adapted to follow social distancing guidance, whilst still maintaining access for new and existing clients, and ensuring uninterrupted prescribing of opioid substitution therapy (OST)
- Arrangements for prescribing and collection of OST if service users need to self-isolate suddenly

What else will need to be put in place:

Naloxone:

- Widen access to take-home naloxone, as well as training in its use, as this can prevent fatal opioid overdoses. There is an increased risk of potentially fatal overdoses if individuals restart drug use following a period of abstinence (e.g. from disrupted street drug supply)

Communications:

- Specific health promotion messages targeted to this cohort (e.g. not sharing any drug paraphernalia where respiratory droplets may be transmitted, such as cannabis joints, cigarettes, vapes, inhalation devices)

Harm reduction:

- Continue testing for blood borne viruses where possible to identify and treat them early; continue operating needle exchange services to prevent blood borne viruses and reduce risk of skin and soft tissue infections. Risk of infection with SARS-CoV-2 is increased for those

sharing drug paraphernalia

Meaningful activity:

- These are helpful to upskill service users, and to distract any urges to relapse. Many activities in substance misuse treatment and recovery are face-to-face: groups, key working, education, training and employment activities. They will need to be delivered via alternative routes, such as online sessions, but some service users may not have the resources or ability to access the internet

Detoxification:

- Government guidance currently recognises that community drug and alcohol detoxification may need to be deferred during the pandemic, but options will need be considered to restart this where possible, as deferral will not be sustainable

Resource capabilities and capacity implications:

Staffing – need business continuity plans to be agreed locally in the event of significant staff absence due to illness

Demand for substance misuse treatment services may increase during, and after, the pandemic:

- Disruption to illicit drug markets because of COVID-19 may lead to reduced street supply of illicit drugs. This may increase demand for drug services
- The increased stress resulting from the general pandemic may increase the prevalence of alcohol use disorder, given that stress is a strong risk factor for its onset and maintenance.

Links to additional information:

Government's guidance for commissioners and service providers of substance misuse services

Appendix 15 - Homeless

Objective:

The objective is to support homeless people during COVID-19, including those who may need to shield or self-isolate, and prevent outbreaks within this vulnerable population and support outbreak management

Context:

Homeless people experience significant health inequalities compared to the housed population and are disproportionately affected by a tri-morbidity of poor physical health, poor mental health, and increased rates of substance misuse. This contributes to accelerated morbidity and mortality: the age of death is significantly lower for homeless people than the general population, at 47 years for men (versus 79.5 years in the general population), and 43 years for women (versus 83.1 years in the general population). In sum, this means homeless people are therefore at greater risk of severe COVID-19, and more vulnerable to the impacts of COVID-19.

During the pandemic, councils have delivered a humanitarian response commensurate with the scale of both the crisis and level of need. On 26th March 2020, the Ministry of Housing, Communities & Local Government asked all LAs to source emergency accommodation for all rough sleepers, or those at risk of rough sleeping, and homeless people living in accommodation unconducive to self-isolation, as part of an 'everyone in' strategy - irrespective of their statutory entitlement to public funds. This has been achieved in the main by sourcing vacant self-contained units in hotels and bed & breakfasts, with individuals allocated private rooms with ensuite bathroom facilities. This requirement, however, is likely to end in the near future, with contracts between some LAs and hotels terminating towards the end of June/beginning of July. The government has also stated that the law regarding no recourse to public funds still remains in place, so the assistance that LAs can lawfully provide is limited.

What's already in place:

Emergency accommodation

- In Medway, rough sleepers have been offered emergency accommodation in a local hotel and shared accommodation.
- One Big Family Kent are helping in Medway to support people. People are provided with three meals per day in a hotel
- A dedicated practice nurse is in place at Halfway Surgery in Chatham to specifically support the homeless population in Medway and encourage this population group to access services and register with a GP. In Medway, homeless nurses at Halfway Surgery are working with people who have No Recourse to Public Funds. Rapid return to country of origin does not allow for re-entry. Rough Sleeping Initiative teams are working to assist them in accessing legal support. British Red Cross can assist them in finding, returning or putting them in accommodation for a period of time. One Big Family, Medway Street Angels, Gillingham Street Angels, Caring Hands and Salvation Army are all supporting people with No Recourse to Public Funds.

Substance misuse:

- Specialist service in-reach: provides wraparound support for homeless substance misusers. They can help accommodation staff troubleshoot substance misuse issues. They can also ensure smooth continuity of opioid substitution therapy prescribing to minimise the need to leave accommodation, and reduce the risk of relapse
- 'Wet' accommodation may be necessary to prevent potentially fatal alcohol withdrawal. It may be necessary to provide alcohol in small quantities to prevent withdrawal, and secure cooperation

What else will need to be put in place:

Medication:

- Develop relationships with local pharmacy to facilitate continued access to medications, including opioid substitution therapy. May require nominated staff members to collect medication, or pharmacies to deliver to accommodation sites
- There have been problems with scripts for people who have been symptomatic in Medway. Turning Point are now delivering in Medway weekly pick-ups instead of daily. There are shared co-produced risk assessments for individuals relating to COVID-19 and support plans in hospital.

GP:

- Work to ensure this cohort is registered with a GP

Isolation Facilities:

- Work to ensure that for isolation purposes no more than one adult is housed in one room and that appropriate facilities are in place in case there is another wave of the pandemic to shield those where necessary

Food:

- Provision (3 meals a day, beverages etc) delivered to all homeless people living in emergency accommodation to prevent individuals from leaving their accommodation unnecessarily whilst self-isolating or shielding – this is likely to be achieved by continuing the Community Support Hub (KRF Vulnerable People and Communities Cell)

Moving on/exit strategies:

- Emergency accommodation in the form of hotels and B&Bs are not sustainable, and the requirement on LAs to house everyone is likely to come to an end shortly.
- Exit strategies need to be developed to provide an offer of support to everyone in emergency accommodation to minimise the risk of individuals returning to sleeping rough, which may include moving residents onto more long-term housing (supported, private rented, social housing) or back to areas where they have a local connection.
- Currently in Medway, each client has a move on plan working with Medway Council housing options/Rough Sleeping Initiative team

No recourse to public funds:

- Moving on strategies for people with no recourse to public funds are particularly important but challenging. The government has stated that the law regarding no recourse to public funds remains in place (Luke Hall MP letter to LAs, 28th May 2020), so it is currently unclear what move on options local authorities can lawfully provide with respect to no recourse to public funds individuals. These will need to be considered with reference to the councils' duties under the Care Act 2014.

Substance misuse:

- Widen distribution of naloxone to mitigate against risk of overdose, as residents may be more likely to overdose if their use of opiates has been interrupted

Mental health in-reach:

- Delivered either by local teams (need to negotiate and agree terms) and/or remotely by existing treatment team if resident is a patient under their care. Need to address the gap in mental health services to both Community Support Hubs and Housing services, particularly from secondary care

Physical health in-reach:

- This gives the opportunity to provide routine medical care to a cohort who are more likely to delay seeking healthcare, and more likely to depend on unplanned emergency services. This is currently in place in Chatham.

Meaningful activity:

- Resident should have access to meaningful activity, given that education, training and employment opportunities are likely to have been paused during this period. This might include TVs, smartphones, internet access, books, and distraction packs

Community homeless provisions:

- Plans to allow community venues, such as soup kitchens, to re-open must consider how to overcome the challenge of social distancing (and lack of compliance with this guidance)

Resource capabilities and capacity implications:

- Staffing levels may become precarious in the event of a second peak – business continuity plans to be agreed
- Housing all homeless people is costly, and the future of central government funding remains unclear
- As the pandemic progresses, there may be new flows of rough sleepers/homeless people into Kent and Medway. Further accommodation may need to be sought for them, which will add pressure to scarce emergency accommodation placements and limited funds

Links to additional information:

NHS England and NHS Improvement COVID-19 clinical homeless sector plan
Groundswell's coronavirus advice for people experiencing homelessness
Government guidance for substance misuse commissioners and providers
Efforts to protect homeless people from COVID-19 in UK

Appendix 16 – Learning Disabilities

Objective:

The objective is to support people with learning disabilities during COVID-19, including those who may be shielding or self-isolating

Context:

Supporting people with learning disabilities takes skill and time. They may not understand concepts such as social distancing and self-isolation. They may require information in alternative formats. Service providers have highlighted the fear of those with a learning disability and their carers. These concerns will need to be considered when suggesting or providing testing for COVID-19. People with a learning disability can often have poorer physical and mental health than other people, which could increase their risk of developing severe COVID-19.

What's already in place:

Alternative communication formats to meet the needs of people with learning disabilities:

- NHS England guidance on learning disabilities and COVID-19: legal guidance; supporting patients unwell with COVID-19 in learning disability facilities; managing patients with a learning disability during COVID-19
- Mencap advice for people with a learning disability and families
- Social care institute for excellence COVID-19 guide for care staff supporting adults with learning disabilities
- COVID-19 videos for people with learning disabilities produced by Surrey and Borders Partnership NHS Trust

General support

- Adult Learning Disability Health Team (Medway Community Healthcare) – for adults (18+) with a learning disability and registered with a Medway GP
- Learning Disability Team (Kent Community Health NHS Foundation Trust) for adults only
- Choice Support Kent, Medway and Essex – supporting people with autism, learning disabilities and mental health need
- Under Kent SEND local offer find guidance for families during COVID-19 outbreak

Mental health:

- Medway Mental Health of Learning Disability Service, which accepts self-referrals

Physical health

- Learning disability annual health checks are part of the solution to prevent further morbidity and premature mortality. These have currently been paused in light of COVID-19 but work is ongoing to reset these

What else will need to be put in place:

Resource capabilities and capacity implications:

Links to additional information:

Appendix 17 – Traveller & Migrating Communities

Objective:
The objective is to support people from Gypsy, Roma, Traveller and other migrating communities

Context:
Gypsy, Roma and Traveller communities experience severe health inequalities, with higher prevalence of some long-term conditions, which may make them more vulnerable to developing severe COVID-19. Shielding and self-isolation may be difficult for members of these communities due to the often confined and communal households, even when considering bricks and mortar accommodation, and restricted living conditions on accommodation sites. Some families will no longer have access to places they may have relied on for water and cleaning purposes, such as leisure centres, churches and petrol station toilets. Others may struggle to find permanent sites on which to pitch.

What's already in place:

- There is a traveller service in KCC and work is also being done between KCC and Kent Community Health NHS Foundation Trust on working with the Roma community in East Kent and Gravesham.
- In Medway, the Community Safety Team will offer welfare checks if there are any incursions. They can also support access to local health services.

Accessible communication:

- Specific guidance developed by Friends Families and Travellers for members of these communities
- Straightforward videos by The Travellers' Times offering general COVID-19 advice and FAQs

Equitable access to education:

- It is important that children in these communities are not disadvantaged due to digital exclusion or physical access to mainstream schooling.
- 'Tutors for GRT' project by Traveller Movement and King's College London's RomBelong programme to connect pupils to volunteer tutors, via WhatsApp video calls, Zoom, or e-mail

Access to healthcare:

- Gypsy, Roma and Traveller communities are already entitled to register with a GP if they reside within their practice boundary, even if they do not have proof of identification/address.

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

- Shielding and self-isolation may be difficult in confined and communal households. Local authorities may need to support these communities in accessing suitable accommodation from which to shield/isolate
- Families may be left without basic amenities (running water, sanitation, electricity) as permanent pitching sites, or places they normally rely upon, are closed or in short supply

- Need to consider LAs response to unauthorised encampments during this pandemic given above pressures on permanent sites – can consider 'negotiated stopping', or installing temporary rubbish disposal, washing and toilet facilities where possible

Communications:

- Future communications must be culturally competent and disseminated in accessible formats and languages for all members of these communities to understand
- Nomadic communities may lack internet access, which may limit their access to health guidelines, education and other online support resources. Temporary WiFi devices may be a quick solution to digitally connect these communities

Equitable access to education:

- Closure of schools and the switch to online learning may disadvantage pupils from these communities. Supplying digital devices (e.g. tablets, laptops) and WiFi access may make home learning easier.

Engagement:

- Need to understand their perspectives, and what support they require from lLAs, incorporating proactive participatory resident engagement where possible. Engagement should be a continued process, instead of a one-off exercise.

Access to healthcare:

- Disseminate accessible information to Gypsy, Roma and Traveller communities to explain their right to register with a GP (see this leaflet). This will be a helpful starting point in addressing the stark health inequalities these communities experience

Resource capabilities and capacity implications:

- Accommodation sites will already be under pressure
- Funding to be able to provide digital and WiFi devices for children in these communities to continue home learning

Links to additional information:

Friends Families and Travellers service directory of Gypsy and Traveller support organisations

Friends Families and Travellers guidance for local authorities to support people living on traveller sites, unauthorised encampments and canal boats

Chartered Institute of Housing guidance on assisting Gypsies and Travellers during the COVID-19 crisis

Lord Greenhalgh's letter to local authorities on mitigating impacts on gypsy and traveller communities

Doctors of the World have published translated COVID-19 advice in 60 languages (written and audio), available here

Appendix 18 – Asylum Seekers

Objective: The objective is to support asylum seekers including unaccompanied asylum-seeking children
Context: There are 3 centres in Kent housing recent unaccompanied asylum-seeking children. Quarantine takes place in accommodation in Oakwood House for two weeks before being moved to Milwood or Appledore. In addition to current COVID-19 concerns, additional quarantine has been needed because there are active cases of tuberculosis (TB) in the camp at Calais. TB testing in unaccompanied asylum-seeking children has therefore also been required.
What's already in place: Government asylum support, including the asylum helpline for free help with asylum support or short-term support
What else will need to be put in place: **Communications** • Culturally competent communications, available in multiple languages, to help asylum seekers access appropriate health prevention and promotion materials **Accommodation** • This will need to be sought to allow individual asylum seekers to quarantine on arrival
Resource capabilities and capacity implications: Limited accommodation: quarantine requires each unaccompanied asylum-seeking children to have their own room for 14 days. There has been a need to find additional space to house all unaccompanied asylum-seeking children as numbers arriving in the ports continue to arrive.
Links to additional information: Government guidance for children's social care services on UASC

KENT & MEDWAY COVID-19 HEALTH PROTECTION BOARD
TERMS OF REFERENCE

1. Purpose

The Kent & Medway COVID-19 Health Protection Board (The Board) will support the local delivery of the next phase of the wider UK government's response strategy to control the COVID-19 reproduction number (R_0), reduce the spread of infection and save lives. This will help return life to as normal as possible, for as many people as possible, in a way that is safe, protects the health and care systems and releases the economy.

The response will be delivered at multiple levels by several different organisations in the region. These levels include:

National
The National Outbreak Control Plans Advisory Board will be established to draw on expertise from across local government and ensure the national Test and Trace programme builds on local capability, and to share best practice and inform future programme development.

Regional
Co-ordination on a regional level will be provided by the South East Incident Coordination Centre and Public Health England South East (PHE)

Local
The COVID-19 HPB will report to respective partner agency meetings (i.e. Medway & Kent Local Outbreak Engagement Board - The Joint Health & Wellbeing Board) with coordination of action across all partners facilitated by The Gold Command Strategic Coordinating Group of the Kent Resilience Forum covering Kent and Medway to optimise the place-based delivery of local health protection plans.

The objective of the Board is to bring these together at a local authority level and provide strategic oversight of the COVID-19 response in the Kent & Medway region allowing for the provision of an integrated response. Under the leadership of the Directors of Public Health for Kent County Council and Medway Council. The Board will design and deliver the Local COVID-19 Outbreak Control Plan (LOCP) to provide a tailored prevention, surveillance and response strategy to reduce the spread of the virus in the area as well as plans to meet any additional needs of the local population.

2. Duties & Responsibilities

The Board will be responsible for the ongoing development and delivery of the Local COVID-19 Outbreak Control Plan (LOCP), this includes:

2.1. Implementing measures, or making recommendations to other bodies where appropriate, that will prevent virus transmission. This may include, those contained within the JBC 'playbook'.

2.2. Monitor testing, contact tracing and infection control capability and capacity, ensuring a swift response in local settings. This will involve:

- Assessing local and regional contact tracing and infection control capability in complex settings by developing assumptions to estimate demand and developing options to scale capacity if needed.
- Ensuring the integration of the NHS Test and Trace programme within local communities and services are in line with the Local Outbreak Control Plan
- Identifying and escalating any issues, including financial challenges, that impact on the ability of the system to effectively function, to the appropriate organisation or agency

2.3. Identifying specific high-risk local complex settings such as care homes, educational organisations and any other places, locations, and communities of interest and developing plans to prevent, respond to and manage local outbreaks in these settings.

2.4. Ensuring local services can support vulnerable people to self-isolate and that wider determinants of health inequalities are addressed.

2.5. Developing and implementing a communications strategy for engaging with the vulnerable populations and high risk communities of interest

2.6. Monitoring the response to local outbreaks by receiving, managing and acting on data and intelligence, including epidemiology and early warning indicators, provided from sources including the Public Health England Epidemiology Cell, NHS Test and Trace, The National Joint Biosecurity Centre, The Kent Resilience Forum – Multi Agency Information Cell and the Kent & Medway CCG COVID-19 Modelling Group

2.7. Ensuring learning is recorded to inform future practice

2.8. Making recommendations for the wider COVID-19 response and policy agenda including the LRF Recovery Workstream, NHS Recovery and Restoration programme and KCC and Medway Council recovery programmes

3. Membership

The members of The Board will be made up of:

3.1. Local Authorities & District Councils

- Director of Public Health (Kent County Council) - Andrew Scott-Clark

- Director of Public Health (Medway Council) – James Williams
- Deputy Director Public Health (Kent County Council) – Allison Duggal (Chair)
- Consultant in Public Health (Kent County Council) – Jess Mookherjee
- Consultant in Public Health (Kent County Council) – Abraham George
- Consultant in Public Health (Kent County Council) – Sam Bennett
- Consultant in Public Health (Kent County Council) – Wendy Jeffreys
- Consultant in Public Health (Medway Council) – Colin Thompson
- Consultant in Public Health (Medway & Kent County Councils) – Logan Manikam
- Consultant in Public Health (Medway Council) – David Whiting
- Public Health Specialist (Kent County Council) – Audrey Beadle
- Public Health Specialist (Kent County Council) – Amanda Nyeke
- Corporate Director for Children Young People and Education (Kent) – Matt Dunkley
- Director of Children & Adult Services (Medway) – Ian Sutherland (TBC)
- Senior Commissioning Manager (Kent County Council) – Sharon Dene
- Commissioning (Medway Council) - TBC
- Health Improvement Manager (Medway Council) – Steve Chevis
- Environmental Health Manager (Dartford & Sevenoaks Borough Councils) & Representative of The Kent Environmental Health Managers Group – Annie Sargent
- Pharmacist - Public Health (Kent County Council) – Sarah Leaver

3.2. Public Health England (South East Region)

- Consultant in Communicable Disease Control – Rachel Pudney

3.3. NHS England & NHS Improvement (South East Region)

- Screening and Immunisation Lead – John Rodriguez
- Screening and Immunisation Manager – Paula McLachlan

3.4. Kent & Medway Sustainability and Transformation Partnership

- STP Prevention Workstream Programme Manager – Jacqui Moore

3.5. NHS Kent and Medway Clinical Commissioning Group (CCG)

- Chief Operating Officer - Gail Arnold
- Chief Nursing Officer - Paula Wilkins

3.6. Other

- Consultant in Virology and Infection (EKHUFT) - Sam Moses (Clinical Lead)
- TBC – (Primary Care Lead)

3.7. Individuals in other roles may be invited to attend where it is warranted by the business of the meeting.

4. Meetings Arrangements

Meetings

4.1. Meetings will be held weekly, but with extraordinary meetings convened if required.

4.2. Meetings are not open to the public

4.3. A draft agenda will be circulated 4 working days before the meeting and the final agenda and papers will be circulated at least 2 working days beforehand.

4.4. The minutes of the meeting will be kept by the appointed Secretary. These will be circulated 2 working days after each meeting and approved at the following meeting.

4.5. Conflicts of interest must be declared by members of The Board

Attendance

4.6. There will be at least six representatives present at each meeting

4.7. There will be least six representatives present for quoracy to be reached, one of whom will be the Chair or nominated Co-chair.

5. Reporting & Accountability

5.1. The Board will be accountable to the

- Local Engagement Board (The Kent & Medway Joint Health and Wellbeing Board)

5.2. The Board will have reporting relationships with the

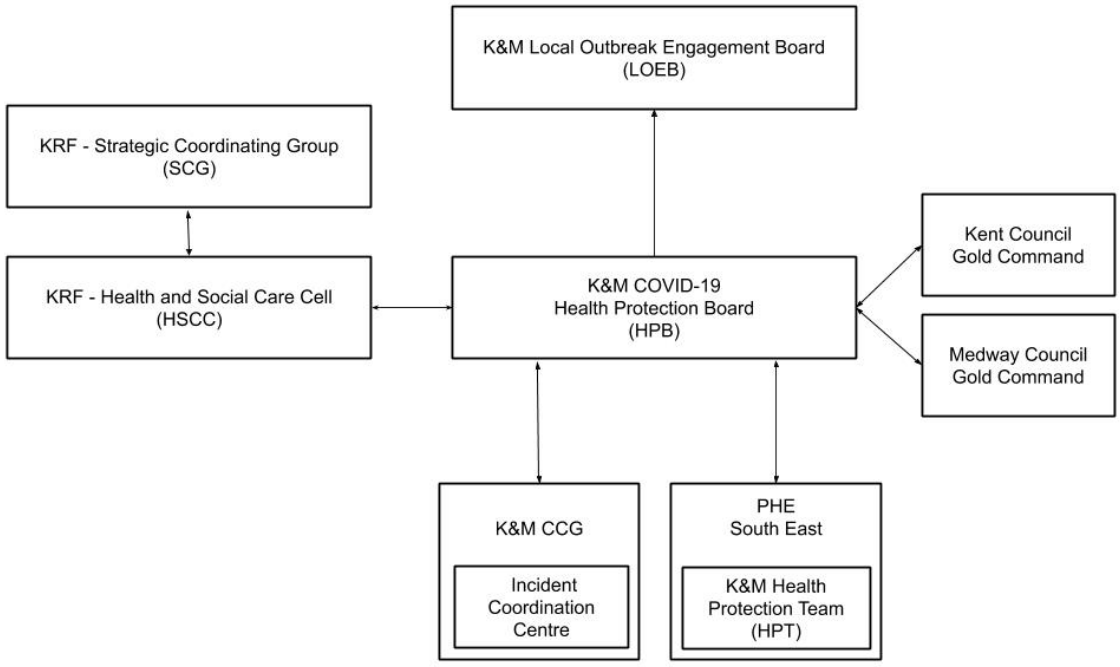
- Local Resilience Forum (LRF) Gold Command Strategic Co-ordinating Group (SCG) for Medway and Kent
- Local Area Contact Tracing Working Groups
  PHE – Kent & Medway Health Protection Team
  NHS E/I - Contact Tracing Working Group

- Medway Council Gold Command
- Kent County Council Gold Command
- Kent and Medway CCG Incident Coordination Centre

5.3. Where appropriate, The Board will liaise with the

- Kent Resilience Forum – Health and Social Care Cell
- Kent Resilience Forum – COVID-19 Testing Workstream
- Kent Resilience Forum – Multi Agency Information Cell
- Kent & Medway CCG COVID-19 Modelling Group

5.4. The reporting structure can be summarised as:



6. Other Matters

Review

6.1. The terms of reference will be reviewed on a bi-monthly basis

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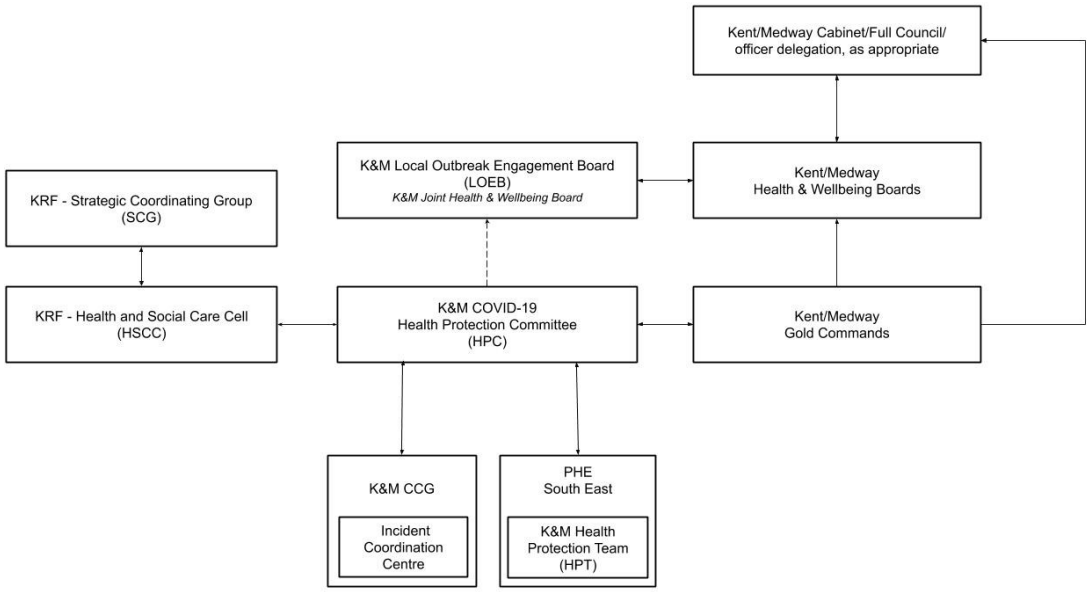
Appendix 3

Key Stakeholders and their Governance Structure in relation to the COVID-19 Health Protection Board for Kent and Medway



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Appendix 4

Health and Wellbeing Board Terms of Reference

A. Operating principles

In line with nationally agreed operating principles the Medway Health and Wellbeing Board (HWB) will seek to:

(i) provide collective leadership to improve health and well-being across the local authority area, enable shared decision-making and ownership of decisions in an open and transparent way;
(ii) achieve democratic legitimacy and accountability, and empower local people to take part in decision-making;
(iii) address health inequalities by ensuring quality, consistency and comprehensive health and local government services are commissioned and delivered in the area; and
(iv) identify key priorities for health and local government commissioning and develop clear plans for how commissioners can make best use of their combined resources to improve local health and well-being outcomes in the short, medium and long term.

B. Key functions

(i) To prepare the Joint Strategic Needs Assessment (JSNA) which identifies the current and future health and wellbeing needs of the local population and may address needs around wider determinants of health.
(ii) To prepare a Joint Health and Wellbeing Strategy for Medway to meet the needs identified in the JSNA.
(iii) To prepare the Medway Pharmaceutical Needs Assessment. Last updated: 28 November 2018 Chapter 3 – Responsibility for functions 3.17
(iv) To encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the people in Medway.
(v) To encourage persons who arrange for the provision of any health related services (ie services that may have an effect on the health of individuals but are not health or social care services) in Medway to work closely with the Board.
(vi) To encourage persons who arrange for the provision of any health or social care services in Medway and those who arrange for the provision of any health-related services in its area to work closely together.
(vii) To provide advice, assistance or other support appropriate for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 (ie arrangements under which NHS bodies and local authorities agree to exercise specified functions of each other).
(viii) To keep NHS commissioning plans under review to ensure they are taking into account the JSNA and local HWB Strategy, referring back to the Clinical Commissioning Group (CCG) or the NHS Commissioning Board where they do not.

(ix) To advise Medway Council's Cabinet of its views on whether the local authority is discharging its duty to have regard to the JSNA and Joint Health and Wellbeing Strategy in discharging its relevant functions.

(x) To involve users and the public in the work of the Board, as appropriate.

(xi) To play a formal role in the annual assessment of the Medway Clinical Commissioning Group.

(xii) To undertake any other functions assigned to Health and Wellbeing Boards in legislation.

Appendix 5

Governance Arrangements for the Kent Health and Wellbeing Board (Updated March 2018)

Role

19.8 The Kent Health and Wellbeing Board (HWB) leads and advises on work to improve the health and wellbeing of the people of Kent through joined up commissioning across the NHS, social care, public health and other services (that the HWB agrees are directly related to health and wellbeing) in order to:

(a) secure better health and wellbeing outcomes in Kent,

(b) reduce health inequalities, and

(c) ensure better quality of care for all patients and care users.

19.9 The HWB has a primary responsibility to make sure that health care services paid for by public monies are provided in a cost-effective manner.

19.10 The HWB also aims to increase the role of elected representatives in health and provide a key forum for public accountability for NHS, public health, social care and other commissioned services that relate to people's health and wellbeing.

Terms of Reference:

19.11 The HWB:

(a) Commissions and endorses the Kent Joint Strategic Needs Assessment (JSNA), subject to final approval by relevant partners, if required.

(b) Commissions and endorses the Kent Joint Health and Wellbeing Strategy (JHWS) to meet the needs identified in the JSNA, subject to final approval by relevant partners, if required.

(c) Commissions and endorses the Kent Pharmaceutical Needs Assessment, subject to final approval by relevant partners, if required.

(d) Reviews the commissioning plans for healthcare, social care (adults and children's services) and public health to ensure that they have due regard to the JSNA and JHWS, and to take appropriate action if it considers that they do not.

(e) Works alongside the Health Overview and Scrutiny Committee (HOSC) to ensure that substantial variations in service provision by health care providers are appropriately scrutinised. The HWB itself will be subject to scrutiny by the HOSC.

(f) Considers the totality of the resources in Kent for health and wellbeing and considers how and where investment in health improvement and prevention services could improve the overall health and wellbeing of Kent's residents.

(g) Discharges its duty to encourage integrated working with relevant partners within Kent, which includes:

i. endorsing and securing joint arrangements, including integrated commissioning where agreed and appropriate,
ii. use of pooled budgets for joint commissioning (s75),
iii. the development of appropriate partnership agreements for service integration, including the associated financial protocols and monitoring arrangements,
iv. making full use of the powers identified in all relevant NHS and local government legislation.

(h) Works with existing partnership arrangements, e.g. children's commissioning, safeguarding and community safety, to ensure that the most appropriate mechanism is used to deliver service improvement in health, care and health inequalities.

(i) Considers and advises Care Quality Commission (CQC) and NHS Commissioning Board; monitors providers in health and social care with regard to service reconfiguration.

(j) Works with the HOSC and/or provides advice (as and when requested) to the County Council on service reconfigurations that may be subject to referral to the Secretary of State on resolution by the full County Council.

(k) Is the focal point for joint working in Kent on the wider determinants of health and wellbeing, such as housing, leisure facilities and accessibility, in order to enhance service integration.

(l) Reports to the full County Council as and when requested on its activity.

(m) Represents Kent in relation to health and wellbeing issues in local areas as well as nationally and internationally.

(n) May delegate those of its functions it considers appropriate to another Committee established by one or more of the principal Councils in Kent to carry out specified functions on its behalf for a specified period of time (subject to prior agreement and meeting the HWB's agreed criteria).

Membership

19.12 The Chairman is elected by the HWB.

HWB: Membership

19.13 Kent County Council:

(a) The Leader of Kent County Council and/or their nominee.
(b) Deputy Leader of Kent County Council.
(c) Corporate Director, Social Care, Health and Wellbeing*.
(d) Director of Public Health*.
(e) Cabinet Member for Adult Social Care and Public Health.
(f) Cabinet Member for Children, Young People and Education.

19.14 Clinical Commissioning Group: up to a maximum of two representatives from each consortium*

19.15 A representative of the local Health Watch* organisation for the area of the local authority.

19.16 A representative of the NHS Commissioning Board Local Area Team*.

19.17 Three elected Members representing the Kent District/Borough/City Councils (nominated through the Kent Council Leaders).

19.18 Notes to 19.12-19.17 - *denotes statutory member.

Procedure Rules

HWB: Procedures

19.19 Conduct. Members of the HWB are expected to subscribe to and comply with the Kent County Council Code of Conduct. Non-elected representatives on the HWB (e.g. GPs and Officers) will be co-opted members and, as such, covered by the Kent Code of Conduct for Members for any business they conduct as a member of the HWB.

19.20 Declaration of Disclosable Pecuniary Interests. Section 31(4) of the Localism Act 2011 (disclosable pecuniary interests in matters considered at meetings or by a single member) applies to the HWB and any Sub Committee of it. A register of disclosable pecuniary interests is held by the Clerk to the HWB, but HWB members do not have to leave the meeting once a disclosable pecuniary interest is declared.

19.21 Frequency of Meetings. The HWB meets at least annually. The date, time and venue of meetings is fixed in advance by the HWB in order to coincide with the key decision-points and the Forthcoming Decision List.

19.22 Meeting Administration.

(a) HWB meetings are advertised and held in public and administered by the County Council.
(b) The HWB may consider matters submitted to it by local partners.

(c) The County Council gives at least five clear working days' notice in writing to each member of every ordinary meeting of the HWB, to include any agenda of the business to be transacted at the meeting.
(d) Papers for each HWB meeting are sent out at least five clear working days in advance.
(e) Late papers may be sent out or tabled only in exceptional circumstances.
(f) The HWB holds meetings in private session when deemed appropriate in view of the nature of business to be discussed.
(g) The Chairman's decision on all procedural matters is final.

19.23 Meeting Administration of Sub Committees. HWB Sub-Committees are administered by a principal local authority, in the case of the Clinical Commissioning Group level HWBs, by a District Council in that area. They will be subject to the provisions stated in these Procedure Rules.

19.24 Special Meetings. The Chairman may convene special meetings of the HWB at short notice to consider matters of urgency. The notice convening such meetings shall state the particular business to be transacted and no other business will be transacted at such meeting.

19.25 The Chairman is required to convene a special meeting of the HWB if they are in receipt of a written requisition to do so signed by no less than three members of the HWB. Such requisition shall specify the business to be transacted and no other business shall be transacted at such a meeting. The meeting must be held within five clear working days of the Chairman's receipt of the requisition.

19.26 Minutes. Minutes of all HWB meetings are prepared recording:

(a) the names of all members present at a meeting and of those in attendance,
(b) apologies,
(c) details of all proceedings, decisions and resolutions of the meeting.

19.27 Minutes are printed and circulated to each member before the next meeting of the HWB, when they are submitted for approval by the HWB and are signed by the Chairman.

19.28 Agenda. The agenda for each meeting normally includes:

(a) Minutes of the previous meeting for approval and signing.
(b) Reports seeking a decision from the HWB.
(c) Any item which a member of the HWB wishes included on the agenda, provided it is relevant to the terms of reference of the HWB and notice has been given to the Clerk at least nine working days before the meeting.

19.29 The Chairman may decide that there are special circumstances that justify an item of business, not included in the agenda, being considered as a matter of urgency. They must state these reasons at the meeting and the Clerk shall record them in the minutes.

19.30 Chairman and Vice Chairman's Term of Office. The Chairman and Vice Chairman's term of office terminates on 1 April each year, when they are either reappointed or replaced by another member, according to the decision of the HWB, at the first meeting of the HWB succeeding that date.

19.31 Absence of Members and of the Chairman. If a member is unable to attend a meeting, then they may provide an appropriate alternate member to attend in their place. The Clerk of the meeting should be notified of any absence and/or substitution within five working days of the meeting. The Chairman presides at HWB meetings if they are present. In their absence the Vice-Chairman presides. If both are absent, the HWB appoints from amongst its members an Acting Chairman for the meeting in question.

19.32 Voting. The HWB operates on a consensus basis. Where consensus cannot be achieved the subject (or meeting) is adjourned and the matter is reconsidered at a later time. If, at that point, a consensus still cannot be reached, the matter is put to a vote. The HWB decides all such matters by a simple majority of the members present. In the case of an equality of votes, the Chairman shall have a second or casting vote. All votes shall be taken by a show of hands unless decided otherwise by the Chairman. For clarity, each Clinical Commissioning Group has one vote, irrespective of whether both the Clinical Lead and Accountable Officer for that Clinical Commissioning Group attend the HWB.

19.33 Quorum. A third of members form a quorum for HWB meetings. No business requiring a decision shall be transacted at any meeting of the HWB which is inquorate. If it arises during the course of a meeting that a quorum is no longer present, the Chairman either suspends business until a quorum is re-established or declares the meeting at an end.

19.34 Adjournments. By the decision of the Chairman, or by the decision of a majority of those members present, meetings of the HWB may be adjourned at any time to be reconvened at any other day, hour and place, as the HWB decides.

19.35 Order at Meetings. At all meetings of the HWB it is the duty of the Chairman to preserve order and to ensure that all members are treated fairly. They decide all questions of order that may arise.

19.36 Suspension/disqualification of Members. At the discretion of the Chairman, anybody with a representative on the HWB will be asked to reconsider the position of their nominee if they fail to attend two or more consecutive meetings without good reason or without the prior consent of the Chairman, or if they breach the Kent Code of Conduct for Members.

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD

28 JULY 2020

WORK PROGRAMME

Report from: Perry Holmes, Chief Legal Officer

Author: Jade Hannah, Democratic Services Officer

Summary

The report advises the Joint Board of the forward work programme for discussion in the light of latest priorities, issues and circumstances. It gives the Joint Board an opportunity to shape and direct the Joint Board's activities.

1. Budget and policy framework

1.1. The Kent and Medway Joint Health and Wellbeing Board (Joint Board) has been established as an advisory Joint Sub Committee of the Kent Health and Wellbeing Board and the Medway Health and Wellbeing Board under Section 198(c) of the Health and Social Care Act 2012.

1.2. The Joint Board operates principally to encourage persons who arrange for the provision of any health or social care services in the area to work in an integrated manner. It seeks to ensure collective leadership to improve health and well-being outcomes across both local authority areas, to enable shared discussion and consensus. Given the responsibilities of both Local Authorities in social care and public health, there is a joint focus on local care and prevention work streams.

2. Background

2.1. Appendix 1 to this report sets out the work programme. It should be noted that the work programme is likely to be subject to frequent changes and additions throughout the year and is for guidance only.

2.2. Members will be aware that agenda setting meetings are held on a regular basis. These give officers guidance on information that Members wish them to provide on an issue. An agenda setting meeting took place on 3 June 2020.

2.3. At this meeting it was recommended that the outstanding matters deferred from the postponed meeting in March 2020 be considered in September. This included the following reports:

- Kent and Medway Joint Health and Wellbeing Board – Case for Change: Children and Young People Strategic Framework

- Kent and Medway Joint Health and Wellbeing Board: Review
- The Strategy Delivery Plan

2.4. Consistent with the proposals set out in agenda item 8 (COVID-19 Local Outbreak Control Plan), it is recommended that an update on the Local Outbreak Control Plan be added to each forthcoming meeting.

2.5. Since the agenda setting meeting, a further request has been received via Mrs Bell to add an additional item to the September meeting, namely to receive a presentation from Dr Robert Stewart, Clinical Design Director, Design and Learning Centre for Clinical and Social Innovation on the DLC innovation project to install devices in care homes enabling residents to have video calls to GPs.

3. Dates of future meetings

3.1. Table 1 sets out the future meeting dates and associated agenda despatch dates. A venue for these meetings is included, however, these may be held as virtual meetings with remote participation as necessary during the pandemic.

Date of Meeting	Agenda Dispatch
17 September 2020 2pm St George's Centre TBC	9 September 2020
8 December 2020 2pm St George's Centre TBC	30 November 2020
10 March 2021 3pm St George's Centre TBC	2 March 2021

Table 1

4. Risk management

4.1. There are no specific risk implications arising from this report.

5. Financial and legal implications

5.1. There are no specific financial or legal implication arising from this report.

6. Recommendations

6.1 The Kent and Medway Joint Health and Wellbeing Board is asked to agree the work programme attached at Appendix 1.

Lead officer contact

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Appendices

Appendix 1 – Work Programme

Background papers

None

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KENT AND MEDWAY
JOINT HEALTH AND WELLBEING BOARD
WORK PROGRAMME

Meeting Date (despatch date)	**Item**
17 September 2020 (9 September 2020)	• Kent and Medway Joint Health and Wellbeing Board – Case for Change: Children and Young People Strategic Framework • Kent and Medway Joint Health and Wellbeing Board: Review • The Strategy Delivery Plan • Local Outbreak Control Plan • Presentation - DLC innovation project to install devices in care homes enabling residents to have video calls to GPs
8 December 2020 (30 November 2020)	• Local Outbreak Control Plan - Update
10 March 2021 (2 March 2021)	• Local Outbreak Control Plan - Update

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