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The first and second waves of the COVID-19 pandemic have passed. Somerset is now embarking on the roadmap out of the third national lockdown. It is time to refresh our approach and interventions to employ, particularly as we now know more about the virus.

COVID-19 is proving to be a disease that clusters in certain geographies and causes outbreaks, due to its infectious nature. Population characteristics can lead to enduring transmission, which requires local knowledge to address. Local Authorities are well placed to lead this work with a statutory duty of wellbeing and employing the Director of Public Health who holds the statutory duty to protect and promote the health and wellbeing of the local population.

The local Somerset Public Health Team, working with Public Health England (South West) and the Environmental Health teams sitting within district councils, have together managed outbreaks of many infectious diseases throughout the year. Outbreak management is not a new responsibility, but from the beginning of July 2020, county and unitary authorities were required to have a COVID-19 Outbreak Management Plan. This version is a refresh of that document, in accordance with central government requirements.

This Outbreak Management Plan sets out how local authorities are, working with Public Health England, the NHS, DHSC, Environmental Health and the National Test & Trace service to manage and contain local outbreaks of COVID-19.

There are now several vaccines being delivered. Furthermore, developments have been made in the supportive management of patients infected with the virus. Primary preventative measures, focused on infection control, remain the first line of defence. This is now particularly important with the development of new variants, that are proving more infectious. Measures such as physical distancing, hand washing, wearing a face covering and ventilating spaces are paramount to preventing and supressing clusters and outbreaks. Additionally, compliance with self-isolation requirements if you are a case or close contact of a case is vital. All these preventative measures rely heavily on the good will and behaviour change of everyone living, working and visiting the county.

Importantly, Local Outbreak Management Plans recognise the important role of individuals, families and communities and this plan has a strong emphasis on engaging
and communicating locally to help people adopt a way of life that reduces the risk of spreading infection and enables us to live with COVID-19.

Trudi Grant
Director of Public Health
1. Introduction

1.1 National and Local Context

Building on the foundation of the statutory role of Director of Public Health and working with Public Health England’s local Health Protection Team, the Local Outbreak Management Plan provides the mechanism for local authorities to anticipate, prevent and contain incidents, clusters and outbreaks in their local area, using their knowledge of and relationship with people and place. The plan gives clarity on how local government works with the NHS Test and Trace Service, the Joint Biosecurity Centre and wider partners to ensure a whole system approach to preventing and managing local outbreaks.

Ongoing engagement and communication with local residents and communities throughout the epidemic is paramount to controlling the spread of infection. The willingness and ability of the local population and visitors, to adhere to infection control measures, is central to the prevention of clusters and outbreak. Keeping transmission as low as possible. This Local Outbreak Management Plan has four key focusses:

- **Preventing** the spread of COVID-19 and preventing poor outcomes from COVID-19 has to be our priority first and foremost. Tools for prevention are growing with the vaccination now being a major strand. Continuing to communicate infection control messages and engage with groups who may
be at greatest risk of COVID or less likely to take up vaccination will be central to the prevention agenda.

- **Identify** and track the local epidemic. Early identification of outbreaks, clusters and areas of enduring transmission are key to their management and controlling transmission.
- **Managing** and responding to local outbreaks and geographical clusters will remain one of the cornerstones of the public health response to COVID.
- **Learning** about the virus and how to contain clusters and outbreaks and respond to areas of enduring transmission will continue to develop. New variants will continue to emerge and will require investigation.

### 1.2 The Somerset Epidemic to Date

Somerset is a largely rural county with a population of around 560,000. About half the population live in towns, with the rest living in less densely populated rural areas. Somerset has approximately 25% of the population over the age of 65, compared to the UK average of 18%.

During the first wave, common with most of the South West region, Somerset had seen lower COVID infection rates that other areas of the country. In the second wave, Somerset had higher rates of infection, but remains around the south west average rates of infection. There have been almost 1,000 outbreaks or cases in high risk settings to date (February 2021).

This refresh of the plan focuses on how we continue to manage outbreaks when they occur, whilst also adapting how we deliver services, particularly around vulnerable individuals (to mitigate the harms associated with the preventative measures) and support our population to change their behaviour to stop the spread of the virus.

### 2. Working in Partnership

#### 2.1 Local Communities and Organisations

The pre-existing strong working relationships in Somerset within and between local government, the care sector, education providers, the NHS, police the voluntary and community sector and the private sector have been reinforced through the first wave of the pandemic. With some fantastic examples of all parts of Somerset pulling together, from local businesses diversifying to provide PPE, to local communities
providing support to the clinical extremely vulnerable population. The community effort has been vast and diverse.

Alongside the local Public Health Team, Public Health England and the national Test and Trace programme, the Environmental Health functions of District Councils have considerable experience and expertise in contact tracing and control of disease. Locally, we have a strong history of working together on risks to health and together have reached out to individual cases, to identify contacts and provide public health advice to isolate. Somerset was one of the first areas in the South West that participated in local contact tracing. As the Local Tracing service becomes fully established, the ability of these local practitioners to reach contacts, and to advise affected businesses and providers on appropriate infection control measures continues to be vital.

Town, City and Parish Councils also have an important role to play. They know their communities well and can play a really important role in supporting and promoting their local communities in infection control measures. They need to play a larger role in representing the interests of their communities, supporting local communication and engagement and providing practical support to help local people to isolate.

The way the voluntary sector and communities have worked together during the pandemic to date has been exemplary. Supporting vulnerable people with essential food and medicinal supplies, setting up online social events and fundraising for NHS and other charities, are just a few of the many activities that made the lockdown tolerable. During the second wave, this support has again been invaluable to their clinical vulnerable residents. Support for people locally identified as vulnerable has expanded to encompass the pressing emotional and mental wellbeing issues. The voluntary sector and communities will remain vital in providing support.

Many of Somerset’s businesses have been hit hard by the implications of the pandemic and many have needed to change their business models to adapt to the challenges faced by physical distancing. It is in everybody’s best interests to ensure we keep the local infection rates as low as possible and local workplaces and businesses have a significant role to play in ensuring they enable people to interact as safely as possible.

Care homes, schools, nurseries, and other educational settings in Somerset have worked incredibly hard to maintain a quality experience for people. Against very challenging conditions they have worked closely and productively with the Local Authority throughout the pandemic to apply national guidance within their settings
and protect against transmission of the virus. These productive relationships continue to flourish and will undoubtedly contribute hugely going forward to being able to keep control of the local epidemic.

2.2 Working in Partnership across the South West

A virus knows no boundaries. Aligning and co-ordinating our response with organisations across the South West, not only makes collaborating easier, but it also means that when outbreaks occur across geographical boundaries, we are all working to the same framework and set of principles.

Under the South West Association of Directors of Public Health (SWADPH), all thirteen Directors of Public Health across the South West have agreed a set of core principles to guide the development of Local Outbreak Management Plans and enable collaboration where needed. These are detailed in Annex I.

Similarly, the Avon and Somerset Local Resilience Forum (ASLRF) is the strategic multi-agency partnership which convenes under the Civil Contingency Act (2004) to plan for and respond to major emergencies across the Avon and Somerset area.

Avon and Somerset LRF is the point of escalation for Directors of Public Health (DsPH) and local authorities if a situation is of severity and scale that, mutual aid or the coordination of strategic partners is required. Arrangements for escalation to ASLRF have been agreed by DsPH.

The line of reporting by DsPH is through the Regional Test, Trace, Contain and Enable Board, which has representatives from PHE, NHSE, the Regional Convenor and the Joint Centre for Biosecurity (JBC). The South West has a strong ethos of working in partnership and, where possible, will continue to collaborate to ensure efficiency and effectiveness.

3. Governance

The governance structure for the Local Outbreak Management Plan can be seen in figure 2 below. The functions of each part of the structure is detailed in the following sections.
3.1 Somerset Local Outbreak Engagement Board

This Board meets in public and is chaired by the Leader of Somerset County Council. It is informed by an Advisory network that has a broad and developing membership to assist real engagement across Somerset’s geography and those communities particularly affected by COVID-19, such as older people, people with disabilities or long-term health conditions, the BAME community and the business community. The COVID-19 Engagement Board’s purpose is to promote maintenance of the infection control measures and gain a greater understanding of the barriers to adopting control measures and provide support if possible. A key role of this board is communicating with and engaging communities to prevent and control outbreaks. The Terms of Reference for the Board can be seen in Annex II.

It is vital that this board is connected to the work of the voluntary sector both organisationally and through the network of health connectors, village agents, and individual volunteers.

This board has, and will continue to publish a weekly COVID dashboard, identifying Somerset’s current epidemic position and providing key messages to feedback to communities. This Board is not responsible for managing individual outbreaks or situations but have an oversight role for the epidemic.
3.2 Somerset COVID-19 Health Protection Board

The Health Protection Board is chaired by the Director of Public Health and meets at least weekly to review the latest data on infections and outbreaks, and actions necessary to control the virus in the county. Membership includes senior leaders and clinicians from the Public Health Team, the NHS, Public Health England, Social Care, Police and with representation from the District Councils and the military.

This Board has the responsibility for overseeing the delivery of the Local Outbreak Management Plan, being the link between the Joint Biosecurity Centre, regional agencies and the NHS Test and Trace system, with the aim of reducing the morbidity and mortality associated with COVID in Somerset. This board informs the work of the COVID-19 Engagement Board and, if required, will mobilise resources and escalate concerns through the ASLRF structures. The Terms of Reference for the Board can be seen in Annex III.

3.3 Regional Test, Trace Contain & Enable Board & Regional Delivery Board

These two regional boards co-ordinate resources and has responsibility to shift resource deployment where needed according to local outbreaks such as surge testing capacity. These boards also enable collaboration and peer learning between areas in the South West, to prevent duplication and strengthen the response.

These groups also have links with the Joint Biosecurity Centre and have a function to liaise with Whitehall and COBR.

3.4 Somerset Health and Wellbeing Board and Shadow Integrated Care System (ICS) Board

The Somerset ICS Board have been receiving assurance on the COVID-19 response in order to inform their functions to improve the health and wellbeing of the population and provide leadership to the health and social care system.

3.5 Somerset COVID-19 Multiagency Recovery Board

The COVID-19 Multiagency Recovery Board and COVID-19 Health Protection Board will liaise in order to ensure recovery is undertaken with relevant infection control measures in place and at an appropriate pace depending on the level of infection in the county.
4. Prevention

4.1 Promoting Positive Health Behaviours

COVID-19 is associated with higher rates of hospitalisation and severe symptoms for people who are older or who those who have poor health. The lockdown, ongoing restrictions, and other mitigations such as social distancing have also impacted negatively on people’s mood and healthy behaviours with indications of a reduction in physical activity levels, and an increase in alcohol consumption and food intake.

If we are to reduce hospitalisations and poor outcomes from COVID-19 it is essential that we continue to enable the population to make healthy choices, in the context of local and national restrictions.

Somerset has continued to provide free health improvement services to the local population throughout the pandemic in line with local and national restrictions. Our Stop Smoking Service is now 100% remote via telephone-based support with staff delivering smoking medications to people’s homes. Zing healthy lifestyle service has been providing online cookery, online recipe books and healthy eating on a budget tips and has started online groups for new mums. SDAS, drug and alcohol services have continued throughout supporting all ages. Health checks have been re-designed to deliver telephone-based Health MOTs for older adults. AGE UK have developed online activity classes and befriending telephone calls for older socially isolated people at risk falling. Somerset’s range of physical activity support has continued in partnership with Somerset Activity and Sports Partnership (SASP) when it can with health walks, online activity classes for local residents, schools and nurseries, Beat the Street Active travel schemes and love to pedal scheme in care homes.

The Long-Term Conditions Cell, chaired by the CCG, provides a forum for ensuring the prevention and treatment pathways for individuals with long term conditions continue to meet the needs of the population at this time. This cell has led a targeted physical activity campaign with individuals who are clinically extremely vulnerable.

4.2 Engagement & Communication

Engagement and communication with Somerset residents is very much driven through the Engagement Board. A Health and Wellbeing Network has been established, made up of a range of organisations and groups which provide a mechanism for two-way communication and aid the management of the local epidemic and improvement in health and wellbeing. The network helps to enhance relationships with groups of
the population that experience poorer health outcomes and provide useful insight into different local beliefs and behaviours.

Engagement with our communities is key to the success of our Outbreak Management Plan. Local surveys have been undertaken with residents across Somerset and groups and communities that form the Advisory Network to understand the barriers people face doing the practical things we all need to do to stop the spread of the virus. Insights from this supports our communications approach and tone of messaging. It also helps us to spot issues and barriers in particular locations.

To ensure the impact of the pandemic is minimised, the population of Somerset need to be engaged with messages that are easy to understand, with a clear logic behind them. A network of well over 100 COVID Champions has been developed and nurtured with representatives from all different parts of the Somerset population. The Champions meet regularly to discuss the local COVID position, give feedback on how messages are landing and what more needs to be done. They offer a route of information to and from particular parts of our community, many of which would be at increased risk and vulnerability.

Communication with Somerset residents and communities has been a central part of the response in Somerset and individual behaviours remain the key to preventing the spread of the virus. Somerset’s approach to communications has been very informed by our engagement work. It is based on the COM B model which highlights three key factors that must change for behaviour change to occur: capability, opportunity and motivation. Motivation is a core part of the model and in particular, recent local surveys undertaken have shown that feeling ‘empowered’ is a key driver for change.

Our communications have been regular, consistent and informed by national and local learning. Where we spot trends and common themes locally that are not addressed by national communication assets produced by PHE, we use our in-house communications team or commission externally to produce infographics, messaging, videos and animations to communicate key information. In particular, over Christmas we produced an interactive animation to show how easy it is to spread the virus within the household by simply sharing items, not wiping down surfaces and lack of ventilation in the home. This animation had over 11,000 views in just 48 hours. We have created a number of graphics designed specifically for workplaces to remind staff of adhering to the guidance even in informal settings with colleagues such as lunch and tea breaks.
We have a productive and reciprocal relationship with our local media who have really played their part in helping to get the messages across to local people through very regular radio and television interviews and a dedicated weekly radio programme to promote health and wellbeing during the pandemic. Much of this media work had been led by the Leader of the Council who has taken an active leadership role in the pandemic response and the Director of Public Health.

We make significant and enhanced use of all forms of social media, targeting specific messages to specific audiences. One particular success has been weekly COVID Update videos covering different topics and issues each week, filmed and produced by a well-known former BBC correspondent. These short video clips have several thousand views each week with fantastic feedback.

We distribute a stakeholder update weekly to a range of stakeholders including health organisations, police, local town and parish councils and other key community representatives as well as sending out a public update twice weekly to communicate the local picture to our residents.

We have been fortunate to have had the support of all MPs and elected members throughout the pandemic, many of whom attend the Engagement Board and provide regular briefings and information back to their divisions. We have held regular briefing sessions for MPs and Elected Members to ensure they kept informed on the current picture and how they can support the Local Outbreak Management Plan.

Going forward, as we begin to ease restrictions and exit the third national lockdown; communications will be built on the local insight that has been achieved through community engagement and through the Advisory Network. This enhanced understanding of our communities will help to shape the approach to communications as part of a phased approach that will be based on the Government’s ’Roadmap’. Different groups will have very different concerns, issues, and barriers so it is vital that we segment our communications accordingly. See Annex VI for communication and engagement strategy and phased ‘burst’ communications plan.

The phases will ensure that our communities understand that we must take a cautious approach to the new freedoms that will be granted and that we must retain the non-pharmaceutical interventions, alongside these new freedoms. Our communications will aim to ensure that people have realistic expectations. We will be clear that the roadmap dates are all to be based on data and may change; the dates set out are the earliest points in which we may reopen, not necessarily will, and that it is with a
collective effort of acting responsibly and cautiously that we can return to a new normal.

A developing element of our local outbreak management plan has been the use of behavioural insights to inform our engagement work. This is being driven forward through the SW ADPH and is an area for development in Somerset, which will help us normalise the ongoing use of non-pharmaceutical interventions.

4.3 Vaccination

The Somerset Mass Vaccination Programme is led by the NHS locally with significant input for Somerset County Council, District Councils and other local organisations. The Mass Vaccination Programme Board meets weekly and monitors delivery of the programme against the nationally mandated milestones.

Vaccination is an indirect tool in local outbreak management. COVID-19 vaccination was not designed to prevent transmission as all vaccines in use were developed to prevent serious illness and death. However, evidence has emerged that the vaccines do lead to a population-level reduction in transmission. Vaccinated individuals may still transmit and contract the virus but are less likely to. Vaccination will not prevent outbreaks but should mitigate their impact.

As of March 2021, the programme in Somerset is progressing well and at one point was identified nationally as having the highest uptake in country. A sustainable plan to continue delivery has been put in place and all milestones have so far been met. There is an ongoing role in ensuring the vaccination programme fits with the Local Outbreak Management Plan, through the Public health team:

- Providing assurance that the public health objectives are being met, particularly in terms of prioritising those most at risk of serious illness and death.
- Ensuring engagement with all of Somerset’s communities but particularly those that are hardest to reach, to maximise take up.
- Ensuring that the vaccination programme is kept abreast of public health evidence, as it develops.

Local vaccination and local outbreak management go hand-in-hand to limit the impact of the pandemic in Somerset, so there are many overlaps between approaches towards testing, social distancing and vaccination. A crucial interface is communications and engagement with communities. Particularly at the early stages of the vaccination
programme, we need to engage with those vaccinated to ensure they follow guidance around social distancing.

Somerset has a Vaccine Inequality Group, led by a Consultant in Public Health, with representatives of all Somerset’s Local Authorities as well as health commissioners and providers. This reports to the Mass Vaccination Programme Board. This group is tasked with ensuring communications and engagement work is co-ordinated as well as targeted vaccination outreach. Data and insight from partners are being used to identify groups and communities less likely to take up vaccination and make sure they are assisted to participate. There is a particular focus on Somerset’s BAME communities and those living in the areas of highest deprivation.

5. Identify - Understanding and Tracking the Local Epidemic

5.1 Identification of cases - Testing

A co-ordinated and timely system of testing and contact tracing is the cornerstone of public health outbreak management and is used across Somerset continuously for a wide range of communicable diseases. Somerset public health staff and District environmental health officers; alongside care setting, schools, nurseries and businesses are practised in this protocol.

The main types of tests for COVID-19 currently being used in the UK are:

- **PCR Swab Test:** This test involves taking a sample of fluids from deep in the nose and throat. It is collected using a swab and so is sometimes called the “swab test”. It is analysed on a machine which uses Reverse Transcription Polymerase Chain Reaction (RT-PCR) and so it may also be called the “PCR test” which looks for genetic material of the virus. We also still sometimes see this referred to as an “antigen” test, but this isn’t quite accurate as this would look for virus proteins (like an LFD test) instead of genetic material. However, the two terms are occasionally used interchangeably to mean a test that answers the question “do I currently have the virus?”

- **Lateral Flow Device (LFD):** This is a simple-to-use point of care solution for rapid COVID-19 testing. It is a new kind of technology that enables the identification and isolation of more asymptomatic people who are at high risk of spreading COVID-19, while minimising disruption for those whose test is negative. It is a 20-to-30-minute test that detects antigens (surface proteins) from the SARS-CoV-2 virus through a throat and nose swab. The test kit can be
stored at room temperature and be processed without the requirement for laboratory technology. Test subjects provide a sample by swabbing their nose and throat. The sample is then prepared and tested through a trained test site operator. The results are processed, and results entered using a mobile app or online portal. Test subjects are notified of results by text and email. As follow-up, people with positive test results are instructed to self-isolate; local health protection teams and NHS Test and Trace are notified.

- **Antibody Test:** Currently, this test involves having blood taken by a trained clinician (phlebotomist). The blood is then analysed to see if the person has antibodies to the COVID-19 virus. If they are present then this means the person has had the virus at some point, even if they don’t remember having symptoms. However, because COVID-19 is a new virus, we still don’t know whether having antibodies mean that a person is immune to catching the virus again. Due to this, we are currently only using the antibody test to find out how many people in total have had the virus. This has started with NHS staff.

Requesting a test yourself if you are symptomatic is managed through the following website [www.nhs.uk/conditions/coronavirus-covid-19/testing-and-tracing/ask-for-a-test-to-check-if-you-have-coronavirus/](http://www.nhs.uk/conditions/coronavirus-covid-19/testing-and-tracing/ask-for-a-test-to-check-if-you-have-coronavirus/)

There are multiple national, regional and local testing programmes that use different technologies and target different audiences. The national testing programme strategy, released on 4 April 2020, outlined a five pillar strategy to scale up our testing programmes.

**There are agreed testing principles, agreed by the South West Directors of Public Health**

**Testing should be purposeful**
- Testing to find cases
- Testing to confirm disease
- Testing to protect those most at risk of harm from the infection
- Testing to contain and control clusters and outbreaks

**Testing and test results need to be timely**
- Delay risks spread of disease

**The reliability of the test used needs to be inform use**
The sensitivity and specificity of the tests used will inform the purpose and use of testing.

**Testing should be linked to wider public health action**
- Testing alone is of little benefit
- It is isolation which breaks the chain of transmission and prevents the spread of the virus
- Testing needs to be directly linked with advice and support to isolate
- Testing needs to be directly linked with identification of contacts – and support and advice, including finance to support isolation

In Somerset the work of all the testing programmes is co-ordinated through the Somerset Multiagency Testing cell and the aims are to:

- **Test to understand the virus** - national programmes – feedback national studies on prevalence and new variants to inform planning and response both locally and nationally.
- **Test to diagnose** - those with symptoms (using PCR tests), either through local hospital laboratories or through DHSC commissioned regional, local or mobile testing sites e.g., hospital patients.
- **Test to protect** - routine testing of those without symptoms (using LFDs) to identify people with asymptomatic illness who are infectious and ensure they and their contacts isolate and stop spreading the infection to vulnerable groups e.g., care homes. Somerset has developed a community testing offer to improve access to asymptomatic testing for workers who need to leave home – details of how to access these sites are available at [https://somerset.maps.test-and-trace.nhs.uk](https://somerset.maps.test-and-trace.nhs.uk)
- **Test to case find** - routine testing using LFDs of those without symptoms to identify people with asymptomatic illness who are infectious and might spread e.g., school or in an outbreak situation.

The Somerset Multiagency Testing Cell oversees all testing programmes delivered in Somerset and reports to the Health Protection Board, this includes prioritisation of testing capabilities. The Somerset testing group is connected to both DHSC and NHS regional testing groups.

For information on testing in Somerset see [Coronavirus – Getting tested (somerset.gov.uk)](https://somerset.gov.uk)
5.2 Contact Tracing

Contact tracing is a fundamental part of outbreak control. When a person is tested positive for COVID-19, they are contacted to gather details of places they have visited, and people they have been in contact with. Those who they have been in contact with 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.

Not everyone that has COVID-19 will have symptoms (asymptomatic), or they may start spreading the virus a few days before their symptoms develop (pre-symptomatic). This is why people who have been in contact with confirmed cases of COVID-19 are asked to self-isolate to reduce the chances of them unknowingly spreading the virus. People might develop the infection anywhere up to 10 days after contact with a person who has confirmed COVID-19.

https://www.gov.uk/guidance/nhs-test-and-trace-how-it-works

The English NHS Test and Trace service was launched on the 28th May to help identify close contacts of cases and advise them to self-isolation, therefore minimise community transmission of COVID-19 and protect those most vulnerable to infection. All the laboratory results from either local, regional or national testing systems feed into the Test and Trace system.

When someone has symptoms of coronavirus they must:

- **Isolate**: as soon as symptoms are experienced, self-isolation must occur for at least 10 days. Other members of their household must self-isolate for 10 days.
- **Test**: a test can be ordered or arranged immediately through the online portal.
- **Results**: if the test is positive, complete the 10-day self-isolation. Anyone in the household must also complete self-isolation for 10 days. If the test is negative, self-isolation can be ceased.
- **Share contacts**: if the test is positive, the NHS test and trace service will send instructions for how to share details of people with whom close, recent contact has occurred. This can be done online via a secure website or over the telephone.

Close contact is defined as:

- Having face-to-face contact with someone (less than 1 metre away)
- Spending more than 15 minutes within 2 metres of someone
• Travelling in a car or other small vehicle with someone (even on a short journey) or close to them on a plane

If the person does not complete this information, they are telephoned by one of the 3,000 professional contact tracers (Tier 2), 24 hours after the initial test to gather this information.

We have been running a successful Local Tracing Partnership for several months and it has proved invaluable in adding to the national contact tracing effort but also in our understanding of local routes of viral transmission.

We are now developing enhanced contact tracing and will be seeking to take this forward further through more formal collaboration with PHE and the NHS Test and Trace Service. We have enrolled to be part of the ‘Local O’ initiative where contact tracing will be led locally. Over the coming weeks we will be increasing our contact tracing capacity to make this vision a reality. This will involve backwards contact tracing to identify if a case of COVID-19 is linked to particular places, such as a health or care settings, an education setting, a prison or hostel. In these instances, more detailed follow up will be undertaken through collaboration between PHE, Somerset County Council Public Health Team, District Council Environmental Health and other regulatory bodies. In these situations, an outbreak control meeting will be arranged to co-ordinate a public health response in partnership with key partners and the setting affected.

5.3 Supporting people to self-isolate

Supporting people to isolate successfully when identified as cases or close contacts is of vital importance in preventing onward transmission of the virus. All adult cases, not linked to social care, get a welfare email from the DPH advising them of the importance of participating in Test & Trace, the need for self-isolation and support available to them.

Early in the response, we set up a helpline to offer support with food, medicines and other essentials, as well as services such as dog walking, working in partnership between the county and district councils, the formal voluntary sector, and the many community groups that were formed in localities. The Somerset Coronavirus Helpline is operated jointly by the County and District Council call centres using a single number 0300 790 6275.
The helpline number has been widely publicised throughout the county. In addition, welfare letters are sent out routinely to all notified COVID-19 cases, making them aware of the support available through the helpline. Our Rapid Outbreak Testing team, deployed to workplaces experiencing outbreaks, also provides information on this support available at the point of testing.

Alongside this support, our district councils administer the isolation payments scheme. To the end of February 2021, the councils have issued 1155 payments. However, it is important to note that the majority of applications are rejected, in particular under the discretionary element of the scheme because they do not meet the criteria, which may undermine compliance with self-isolation.

5.4 Identification of cluster and outbreaks

National Local Outbreak Management funding has enabled establishment of a dedicated Public Health Cell which co-ordinates the practical day to day work of outbreak management. This includes the allocation of staff resource, liaison across partner organisations, outbreak management decisions and data analysis and integration.

If risks are identified around securing an organisational response, these are logged onto the SCC JCAD risk system and managed through this process. The JCAD system is held centrally and a dedicated risk manager is in post. If there are wider system risks these are escalated to the Somerset COVID-19 Health Protection Board and managed as required.

The cell operates a daily huddle to ensure prompt identification of cases linked to high risk settings, outbreaks and clusters. It ensures co-ordinated response to outbreaks and escalates these situations when there are concerns. This cell has responsibility, in liaison with Public Health England, to identify, co-ordinate and close outbreaks as well as capture learning for ongoing development of practice.

This cell also ensures that, following notification of specific outbreaks or situations to SCC Public Health, relevant stakeholders are informed, with the correct information to enable a co-ordinated response, according to agreed processes. The SCC Public Health team have been working closely with Adult and Children’s Social care teams, education colleagues, primary care, NHSE/I and infection control nurses across the system. This multidisciplinary team across the system provides surge capacity to deliver robust outbreak management.
An epidemiology cell is part of the Public Health cell and this group undertakes surveillance and analyses the current outbreak position across Somerset. It looks at intelligence gathered from contact tracing and uses local knowledge and current case data, to identify if specific actions need to be undertaken to contain transmission.

The Public Health Cell continues to provide specialist public health advice to the COVID-19 Engagement Board and COVID-19 Health Protection Board.

5.5 Enduring Transmission

As more is known about how the virus behaves, we learn how to effectively contain its spread and reduce adverse outcomes. A recent analysis by the Joint Biosecurity Centre identifies a framework to approach enduring transmission in a local area focusing on two areas:

a) key local events e.g., the tourism season, Christmas holiday return of university students to Somerset,
b) continued impact factors e.g., areas of deprivation, employment and occupation risks, demographic and household compositions, attitudes and behaviours of different segments of the population and response aspects.

We have a good understanding of parts of the Somerset geography that have experienced more enduring transmission and have already put in additional measures such as increased testing, increased enforcement activity and a focus on communication and engagement.

At times of significant outbreaks our local Elected Members have played a really key community leadership role and have been incredibly helpful in providing local insight, quashing local myths and reassuring people.

Somerset has experienced higher levels of transmission within certain sectors such as health and care, food manufacture, construction and tourism, these sectors are considered in more detail in section 6. Again, we have focussed attention on these sectors and will continue to work productively with local employers to reduce and control the spread of infection as well as continue to develop our understanding of areas and settings of greatest risk. Arguably the outbreak response is the easiest part, it is the pervasive inequalities that exist within and between populations that are often driving transmission, and this is informed by intelligent use of data locally.
5.6 Data Integration

The Somerset Public Health team will lead the data integration process for Somerset to support Local Outbreak Management working in collaboration with colleagues across the system.

There are a number of data feeds which will be used inform the Local Outbreak Management Plan. These include:

- National and regional alerting of activity hotspots and modelling of the epidemic.
- Community resilience, numbers and locations of vulnerable individuals and settings.
- Symptom reporting, 111 / 119, primary care, other self-reported cases.
- Number of cases detected via the different testing routes through a daily line list of positive cases of COVID-19.
- Test and Trace feedback.
- Local outbreaks information covering schools, care homes and other vulnerable settings.
- Hospital and Social Care capacity and analysis of inpatients.
- Deaths reported in different settings.
- Vaccination coverage.
- Demographic data.

On behalf of the COVID-19 Engagement Board, the local Public Health Team have developed a COVID-19 dashboard which shows the epidemiological picture of the local epidemic. An example dashboard can be seen in Annex IV.

Considerable progress has been made across Somerset to ensure appropriate data sharing and regular data flows are in place in order to track and manage the epidemic. National data flow issues have largely been resolved to provide the most complete picture of the epidemic for Somerset.
6. Managing Outbreaks and Clusters

6.1 Overview

To date Somerset has been notified and responded to almost 1,000 outbreaks of COVID-19. As the number of outbreaks and complexity have increased, a system-wide model has enabled a co-ordinated response, this has required additional recruitment and training. As we enter this next phase of the response the dedicated health protection response team will be expanded, to enable non health protection public health business to return, alongside the ongoing response.

National definitions are used to graduate the response to confirmed or probable cases, situations, cluster and outbreaks. See: https://www.gov.uk/government/publications/covid-19-epidemiological-definitions-of-outbreaks-and-clusters/covid-19-epidemiological-definitions-of-outbreaks-and-clusters-in-particular-settings

Within Somerset we have an existing Memorandum of Understanding (MOU) (2015) that outlines how key partners work together to reduce morbidity and mortality associated with outbreaks.

The following section details specific work in particular high risk settings to ensure prompt identification and response to outbreak in these settings, based on the increased risk of either poor health outcome for residents or an increase in community transmission.

6.2 Adult Care Settings

Somerset County Council (SCC) prides itself on having long had robust and supportive oversight arrangements in place with our care provider market. The proportion of Good and Outstanding-rated care provision in the county exceeds national and regional averages, and SCC work closely in partnership with the Registered Care Providers Association (RCPA), Care Quality Commission (CQC) and Clinical Commissioning Group as part of routine commissioning and quality oversight activity.

Based on latest available CQC Directory information (1 June 2020), there are:

- a total of 218 Residential and Nursing Homes in Somerset, including services supporting adults with learning disabilities and enduring mental health needs. Of these, 186 (85.3%) are rated by the independent regulator, the Care Quality
Commission, as being Good or Outstanding. 31 ‘Requires Improvement’ and 1 is ‘Inadequate’.

- 64 community-based adult social care services, of which 61 (82%) are judged ‘Good’ or better by the CQC. No domiciliary care provision is rated inadequate in the county.

Additionally, there are currently 575 micro-providers working across the county - paid professionals providing local services for people needing some help and support.

Adult Social Care, Public Health, the Clinical Commissioning Group, NHS providers, CQC and the RCPA have been working hard with care providers to support them to manage and respond to the unique pressures that COVID-19 has placed upon them and take all possible steps to mitigate and prevent the spread of the coronavirus. A summary of local activity to support care settings during the COVID pandemic was published on 29 May 2020 and is available here: https://www.somerset.gov.uk/coronavirus-support-for-adult-social-care-providers/.

All process for care providers to take on all aspects of COVID-19 e.g., testing, notification of cases of COVID-19 and response to an outbreak are published at: https://ssab.safeguardingsomerset.org.uk/covid19/

6.3 Education and Children’s Care Settings

Early years provision (0-5 years) in Somerset is provided by a range of different settings. There are a total of 567 early years settings. Of these 188 are school run provision, 264 registered childminders and 185 Private, Voluntary and Independent Sector (PVI) providers.

In Somerset there are 268 state funded schools. Of these, 217 are primary schools, 8 are middle schools, and 2 are all through schools. There are also 4 pupil referral units and 9 special schools. In total 71,190 pupils in Somerset attend a state funded school. There are four further education colleges and two university centres.

There are 24 independent schools in Somerset attended by just over 8,000 pupils.

All national guidance relating to education and childcare settings is available here: https://www.gov.uk/coronavirus/education-and-childcare
There is a multiagency group including representation from local authority education leads, public health, health and safety, and head teachers, which is chaired by SCC Education that has been working hard to put plans in place for schools to operate within the COVID-19 secure guidance and understand how to respond to suspected or confirmed cases or outbreaks of COVID-19.

All schools are following government guidance for social distancing and have in place measures such as teaching in bubbles, staggered drop off and pick-up times, and reduced class sizes.

The Director of Children’s Services is in regular communication with schools. The decision for schools to remain open currently lies with the individual schools, however, this may be influenced by Public Health advice in the context of an outbreak.

If there are increasing rates of COVID-19 within a particular community this would be discussed at the COVID-19 Health Protection Board. Any appropriate communication to stakeholders and actions would be taken. All information regarding COVID-19 guidance and processes is hosted on the Support Services for Education (SSE) website: http://www.supportservicesforeducation.co.uk/Page/17461.

Any update to the guidance is communicated to schools through the daily SSE bulletin which is distributed to all schools.

6.4 Children’s residential settings

Children’s residential settings cover schools and housing provision for children looked after. There are 550 children in care across Somerset who are accommodated across a range of settings. Approximately 500 households are offering foster care provision and there are 35 Ofsted registered children’s homes in Somerset offering homes for children and young people from within and beyond Somerset. The ‘pathways to independence’ programme offers supported accommodation to vulnerable young people in 37 properties.

There are 17 independent non-maintained special schools which offer a range of day and residential places to children with complex needs. Of these, 7 offer residential care.

Residential school settings are considered as a household for the purposes of isolation. The isolation unit will depend on individual circumstances e.g., could be a dormitory or an isolated building. The HPT can help schools with the risk assessment and the
defining of a group/ household that needs isolation. If a student or staff member develops symptoms whilst away from the school setting, they should NOT return to school and must self-isolate at home. If a student/ staff member has been in contact with someone with symptoms at home, they need to self-isolate at home and not return to the school.

These settings are likely to have staff visiting rather than residing on site. In such circumstances, infection control procedures for staff entering and leaving the site are crucial.

All residential schools and children’s homes have been provided with IPC guidance and PHE documentation regarding the prevention and response to suspected cases of COVID-19. Specialist IPC support is available from the CCG IPC nursing team.

All residential settings are encouraged to notify PHE of any suspected or confirmed cases in students or staff. The PHE SOP for educational settings also includes guidance for residential settings.


6.5 High Risk Major Employers and Businesses, including Major Tourism Sites and Large Events

Somerset is renowned for its food and drink, and has a significant number of food processing businesses, notably meat and dairy, but also ready meals and a range of other businesses. Experience elsewhere in the UK and abroad has shown that some food processing establishments seem to be at higher risk of COVID-19 outbreaks, notably slaughterhouses and poultry processing plants. We have worked with this sector to prevent outbreaks, as well as managing them if and when they occur.

Somerset is also a major tourist destination and as the economy opens up, some of our major holiday destinations will face increased risks of outbreaks. These destinations have well-rehearsed outbreak plans for more common diseases such as norovirus. Work on this local outbreak management plan will continue to ensure that these businesses are supported in being COVID Secure, to minimise risk of infection.
In the event of an outbreak at a major workplace Somerset Public Health and environmental health services work with the regional PHE Health Protection Team, HSE where appropriate, the NHS locally and site management through well-established outbreak control team processes. This team works to understand the epidemiology of the outbreak and what additional steps are required to bring the outbreak under control, including any spread into the wider community from the establishment.

Somerset is also home to the largest construction site in Europe, the EDF Hinkley Point C nuclear power plant, which also has associated premises including accommodation campuses in Bridgwater and at site. This project is a nationally significant infrastructure project that has continued the build through lockdown, with a reduced workforce of about 2,500 people to enable physical distancing. EDF has introduced a whole raft of measures to minimise risk of infection, including in-house PCR testing and more recently antibody testing. Hinkley Point has an outbreak plan and a national team that can be deployed to site in response to an outbreak. EDF work closely with SCC Public Health and PHE.

6.6 High risk places, locations and communities that experience inequalities

Somerset has a number of settings where an outbreak of COVID-19 is likely to have adverse health consequences. For example, the homeless people hostels, businesses that have a high proportion of workers who are not engaged with local health services, or where social distancing is challenging, or where there are a number of vulnerable individuals.

Somerset has seen significant in-migration, predominantly from the European Union, over the last 12 years in particular, with significant parts of the workforce in agriculture, food, tourism and other parts of the economy. In addition to the employment location, these communities can also be at increased risk due to:

- shared and/or communal housing, sometimes of poor quality, sometimes overcrowded
- English as a second language
- insecure employment
- low pay
- minimal sick pay provisions
- no recourse to public funds status
These types of conditions can make outbreak investigation challenging and resource intensive, typically requiring on the ground contact tracing and translation services. From experience, this requires public health, environmental health staff and housing officers with detailed local knowledge, plus excellent contact tracing skills. There are also barriers around achieving compliance with self-isolation of contacts for 10 days, due to the poor financial position many would find themselves in.

There are similar issues arising in relation to the homeless and rough sleeping population, with hostels identified as a high risk location. Again, local staff with a good understanding of local support services around homelessness, drugs and alcohol, mental health etc are vital. Working with local specialist agencies who are able to continue providing support is essential. The swift removal of shared/communal sleeping arrangements in hostels was also a crucial move and Districts are working hard to make sure they do not return any time soon. This approach has been incorporated in cold weather and emergency provision.

7. Vulnerable and Underserved Communities and Those at Increased Risk of COVID-19

Work to support specific people at increased risk of COVID-19 has been joined up and co-ordinated across numerous organisations. This work has identified and supported vulnerable people with basic needs: food and medicines, access to accommodation and emotional wellbeing. This has included delivery of support for clinically extremely vulnerable people. As a partnership between Somerset’s District Councils, County Council and CCG, the Community Resilience and Vulnerable cell have continued to co-ordinate accommodation and support to rough sleepers, support for people experiencing domestic abuse and support for children and adults identified locally as vulnerable.

The approach has been a strength-based approach to develop a contact strategy to reach the most at risk in Somerset building on the infrastructures and relationships across the health, care and VCS system in Somerset.

The county continues to deliver the Somerset Coronavirus Helpline, effectively creating one number for people to call to get in touch with services in one place. This has been extensively promoted through social and local media.

The pathway to contact and support people identified as vulnerable (including clinically extremely vulnerable) has developed into a stepped approach. Volunteers in
the community are supported and co-ordinated through Spark Somerset. These provide support to deliver food and medicine and provide welfare contact. Village Agents and other social prescribing link workers proactively contact those that are more isolated or require additional support. County and District Council staff are also contacting those that have been hard to reach. This support will continue to be vital to prevent the spread of the virus amongst those most vulnerable to the virus.

District Councils continue to fulfil their responsibilities to provide rough sleepers with accommodation. This includes emergency accommodation triggered by cold weather which has been reconfigured from previous years to make it COVID secure, including access to rapid testing for people showing symptoms and single occupancy rooms.

All for rough sleepers and existing homeless hostels have clear plans for responding to individuals with symptoms of COVID-19. It is vital to ensure that living arrangements for these individuals continue to support self-isolation if required, to prevent virus spread amongst this group.

All agencies involved in Somerset’s COVID-19 response have been unequivocal in supporting the Government’s social distancing guidelines. This included not leaving home at all, except for the four permitted reasons during the “lockdown” and continues to include not travelling for overnight stays outside the home.

The support for Gypsies, Travellers and Nomadic people has been put in place to reduce movement wherever possible and to take a pragmatic approach to reduce risk. Avon and Somerset Police and Somerset’s District Councils have agreed not to take enforcement action against Travellers at this time unless there is a safety risk. This reduces the need for onward movement and potential contact with further members of Somerset’s settled community. Infrastructure has been established to allow washing and therefore further reduce infection risk.

Somerset has relatively small BAME populations but with many long-standing relationships which have enabled good engagement through programmes like the COVID Champions. The County Council and NHS Trusts locally have put in place support mechanisms for their Black, Asian and Minority Ethnic (BAME) staff due to the increased risk from COVID for some minority ethnic people. PHE have recently published new guidance and any appropriate measures necessary to support BAME people as part of outbreak prevention and management will be deployed locally.
The Somerset advisory network is made up of community champions representing the views of vulnerable and underserved communities and people. These voices and views are used to shape both preventative and response activities.

8. Learning

8.1 New Variant of SARS-CoV-2

The emergence of variants of SARS-CoV-2, the virus that causes COVID-19, serve as a powerful reminder that viruses by their very nature mutate, and that the scientific response may need to adapt if they are to remain effective against them.

Some variants have been identified as Variants of Concern (VOC). These include:

- “Kent” variant (VOC202012/01) which likely emerged in September 2020 and appears responsible for the higher numbers of cases in Kent despite national restrictions being in place. This variant has multiple mutations in the spike protein, which is the part of the virus which first attaches to a human cell. These changes have resulted in the virus becoming about 50% more infectious and spreading more easily between people. This strain probably now accounts for about 80% of all new cases in the UK.

- “South African” variant ((VOC202012/02) which emerged around the same time as the Kent variant. It shares the same mutation to the spike protein as the Kent variant but also has a number of other mutations including E484K which means it may be able to escape the body’s antibodies to some extent and is therefore of potential public health concern. Cases with this mutation are currently being followed-up closely and monitored in the UK. In some areas where there are people who have the variant but have not travelled to South Africa extra case finding is being undertaken using “Project Eagle”.

- “Manaus, Brazil” variant (VOC202101/02) which has similar spike protein mutations to the South African variant.

- “Bristol” variant (VOC202102/02), which is similar to the Kent variant but has the same E484K mutation as the South African variant and led to extra testing being put on to identify cases in the Bristol and South Gloucestershire area. There is currently no evidence this mutation alone causes more severe illness or greater transmissibility.
There are other variants that are “variants under investigation” (VUI) and this includes another strain from Brazil, a strain in Liverpool which is similar to the Bristol strain, and a new variant from Nigeria. There is currently no evidence that these variants cause more severe illness or increased transmissibility, but Public Health England continues to monitor the situation.

The ONS random testing of 5% of PCR tests submitted to laboratories across the UK provide good surveillance of emerging variants of SARS-CoV-2. In Somerset PHE would communicate to the DPH if and when there are cases of either Variants of Interest or Variants of Concern of SARS-CoV-2. Somerset was involved in Operation Eagle, the response to new variant cases in Bristol and South Gloucestershire and have undertaken planning to enable the rapid deployment of surge testing with the use of DHSC MTUs and the rapid stand up of local test collection and drop off points. This would work alongside enhanced contact tracing of cases provided by PHE.

The current response is one of surveillance and standby to act, should any variants of concern be identified. Surge testing plans are in place in Somerset should they be needed.

8.2 Learning from outbreaks

Learning from outbreaks across the county, as well a learning being brought in from outside the county is captured and considered at the Health Protection Board. This learning has been invaluable to shape our local response and inform the support and communications that have been provided locally. There has been an open culture of learning across organisation, enabling people to share their experiences in order to benefit the county as a whole.

9. Looking Forward

9.1 Resourcing and capacity management

A significant proportion of the local response has required the redeployment of significant numbers of staff from across the Somerset system. There is now a need for services to be fully stood back up thereby, requiring staff to go back to their normal roles.

Planning and recruitment is underway for the development of a Health Protection Unit that will continue to manage outbreaks on an ongoing basis, led by the Director of
Public Health and a Public Health Consultant - Health Protection. Planning for this unit is for a two-year time period until March 2023, to attract high quality candidates and ensure Somerset is able to respond to COVID outbreaks (as well as other health protection incidents) for the foreseeable future. During this time, it is assumed that the infection rates will be controlled and there will be greater clarity on the new Institute of Health Protection and any future additional health protection function that the local authority will be required to provide. Obviously, during this time there will be variable infection rates and therefore any excess capacity in this team will be used to assist with the recovery from the pandemic.

The Local Authority has successfully recruited to a number of the specialist public health posts within this new Unit and now continues with increasing capacity within contact tracing.

9.2 COVID-19 secure standards, compliance and enforcing the guidance

Somerset is planning for the future to adapt to how we ‘live with COVID-19.’ A key element of this is to ensure that business, workplaces, leisure sites, tourism venues and people in their everyday lives adopt the ‘cCOVID-19 secure’ practices that prevent the spread of the virus.

The Somerset Public Health Team work closely with Environmental Health and Licensing colleagues in the District Councils, the Trading Standards partnership, and with the Police. Existing working relationships are strong, but an Enforcement Intelligence Cell meets at least weekly to share intelligence and public health data, to share resources where necessary, to develop common guidance and approaches, and to share good practice. The focus of this is to ensure that business and events adhere to the COVID-19 secure standards and put the necessary mitigations in place.

Co-ordinated dialogue on proposed events in the County, and outbreaks associated with various food manufacturing plants and other employers has been very beneficial, including liaison with other agencies such as the Health and Safety Executive and PHE.

Funding has been provided by Somerset Public Health to enable the Environmental Health Teams to engage a dedicated Covid Support Officer in each district to bolster enforcement resources, and a Somerset Events Covid Support Officer will be deployed across Somerset to assist with delivery of the national roadmap and opening up of events.
Enforcement powers have been used by the District Councils to close some premises, but the overall approach has been to inform and advise businesses, seeking to support them to understand and comply with the changing requirements. Our approach has been to Engage, Explain, Encourage and only Enforce as a last resort.

The Enforcement Intelligence Cell has also worked collaboratively to appoint Covid Wardens (also known as marshals) to work across the County. This work has been co-ordinated by Sedgemoor District Council as the employing authority, with a schedule of patrols/visits co-ordinated with partners. Three additional wardens have been recruited to start in March 2021 to support the re-opening of the economy and tourist sector as part of the Government’s roadmap out of lockdown. Two of these posts will be dedicated to the Sedgemoor District and the coastal areas of Burnham, Berrow and Brean. South Somerset District Council also employ a dedicated warden for their area.

A Somerset Contain Strategy has been developed to define how the County Council’s Direction powers can be used in partnership with District Environmental Health Officers who have been authorised and trained to take action on behalf of the County Council where necessary.

10. Summary, Conclusions and Requests

This revised document has set out the COVID-19 Local Outbreak Management Plan for Somerset. It details a proactive approach to preventing and managing COVID outbreaks by identifying and supporting high risk settings and groups. Identification of outbreaks and clusters through rigorous attention to new cases and strategic use of testing capability will be key.

The document details comprehensive outbreak management in close liaison with partner agencies and with specific plans in place for surge capacity. It details the processes for practical support and robust infection control guidance.

The importance of engagement and communication with the public is highlighted throughout the plan, led by the COVID Engagement Board and an Advisory Network that can be inclusive and grow over time.

It is acknowledged that the plan will need to flex and be reviewed as the needs of the local epidemic change, the scientific evidence changes, as national alert levels are changed, and as national policy is amended.
10.1 Requests of the National Contain Team and Central Government

In refreshing this Local Outbreak Management Plan there are a number of requests that would assist with the implementation of the plan and the local response going forward:

- Extension of the Outbreak Management Funding provided to Local Government for a further year to March 2023. This would allow greater employment stability and help to attract people into the roles. This funding is currently extended to 2022 which is likely to lead to people coming towards the end of their contract period and looking for new work just before winter next year when it is likely we will need to have robust arrangements and workforce in place.

- Somerset has not benefitted from wastewater surveillance to date and we would very much welcome this development to help inform our Local Outbreak Management Plan.

- Early discussion, notification and funding for any enhanced Health Protection role for Local Government going forward. The local authority public health role during the pandemic has gone far and above the health protection assurance role given to local Directors of Public Health in the 2013 Health and Social Care Act.

- Continued development of the dialogue between the national, regional and local COVID responses. This collaboration has improved as we have progressed through the pandemic but needs to continue to be developed so national developments can be informed by local intelligence and local areas can be given due notice of any change in policy or guidance direction.
Annex I: Principles Agreed by South West DsPH

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

2. While recognising local sovereignty we will commit to ensuring a common language to describe the local governance arrangements:
   a. COVID-19 Health Protection Board
   b. Local Outbreak Management Plans
   c. Local Outbreak Engagement Board (While Local Authorities may have an established Board/Committee they wish to undertake the function of this Board e.g. Health and Wellbeing Board, it is important that within the title they include the title Local Outbreak Engagement Board)

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

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

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

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

7. We will ensure that within our planning and response to COVID-19 we will plan and take the necessary actions to mitigate and reduce the impact of COVID-19 on those most vulnerable, including BAME communities.
8. We recognise that DsPH have a system leadership role in chairing the COVID-19 Local Health Protection Board. We commit to actively engaging with key partners, including all levels of government (Upper, lower tier local authorities, towns and parishes and wider partners and communities), key stakeholders including the community and voluntary section to ensure a whole system approach.

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

10. We will ensure that our Local Outbreak Management Plan includes a strong focus on prevention and early intervention to ensure key settings (e.g. care homes and schools) and high risk locations and communities identify and prioritise preventative measures to reduce the risk of outbreaks.
Annex II: Somerset COVID-19 Engagement Board Remit and Terms of Reference

1. Background

1.1 The Department of Health and Social Care on the 22nd May 2020 instructed all upper tier authorities and their public health team to establish specific COVID-19 Health Protection Boards that will have a remit to oversee the delivery of COVID-19 Local Outbreak Prevention and Control Plans. The COVID-19 Health Protection Board should be supported by a public-facing politically led Board to communicate openly with the public; a COVID-19 Local Engagement Board.

1.2 Local Authorities have a significant role to play in the identification and management of COVID-19 outbreaks. The purpose of Local Outbreak Management Plans is to give clarity on how local government works with the NHS Test and Trace Service to ensure a whole system approach to managing local outbreaks.

1.3 Building on the foundation of the statutory role of Director of Public Health, working with Public Health England’s local Health Protection Teams, the Local Outbreak Management Plan will provide the mechanism for local authorities to anticipate, prevent and contain incidents and outbreaks in their local area using their knowledge of and relationship with people and place. The Director of Public Health will be responsible for defining these measures working through the Somerset COVID-19 Health Protection Board.

1.4 Somerset is a largely rural county with a population of around 560,000. About half the population live in towns, with the rest living in less densely populated rural areas. Somerset has approximately 25% of the population over the age of 65, compared to the UK average of 18%.

1.5 In common with most of the South West region, Somerset has to date seen lower COVID-19 infection rates that other areas of the country. Nevertheless, there have been almost 70 separate outbreaks in the county (at 18 June 2020).

1.6 New infections are now at low levels in the county, and the next phase of living with COVID-19, which we should plan to do for up to two years while we await an effective vaccine and/or treatments, is to open up the county carefully with
strong disease surveillance in place, and an ability to tackle outbreaks as swiftly and effectively as possible.

1.7 The willingness and ability of the local population and visitors to adhere to infection control measures will be paramount to controlling the spread of infection. The Director of Public Health and the Somerset COVID-19 Health Protection Board will provide advice to the Somerset COVID-19 Engagement Board to support it in its purpose of engaging with the local community in these endeavours.

2. Purpose and Duties of the Board
2.1 Purpose
To lead and enable engagement and communication with public, communities and partner organisations in the effective management of the COVID-19 epidemic in Somerset

2.2 The Board will promote the maintenance of the infection control measures and gain a greater understanding of the barriers to adopting control measures so support can be provided if possible. A key role of this board will be communicating with and engaging communities to prevent and control outbreaks.

2.3 Duties of the Board
2.3.1 The Board will engage with Somerset’s communities on the ongoing requirement for infection control measures, identify where infection control measures are going well or, where they may need further consideration (within the national guidelines and the current evidence-base), particularly around barriers to following social distancing, self-isolation or shielding advice.

2.3.2 The Board will communicate the status of the local epidemic weekly and will engage communities and local leaders with the management of significant outbreaks as appropriate. It will publish a weekly COVID dashboard, identifying Somerset’s current epidemic position and providing key messages to feedback to communities. This Board would not be responsible for managing individual outbreaks or situations but would have an oversight of the epidemic.

2.3.3 The Board will provide oversight of the local epidemic and assure delivery of the Somerset Local Outbreak Management Plan.
2.3.4 The Board will host an Advisory and Engagement Network made up of a range of organisations and groups which will provide a mechanism for two-way communication to inform and aid the management of the local epidemic.

This network should include representatives from:
- Visit Somerset
- Faith Leader
- Black, Asian and Minority Ethnic Groups
- Voluntary and Community Sector
- Healthwatch
- Somerset Youth Parliament
- Mendip District Council
- Sedgemoor District Council
- South Somerset District Council
- Somerset West & Taunton District Council
- Somerset NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

2.3.5 The Board will ensure the support to vulnerable people who are shielding, or self-isolating is robust and meeting local people’s needs.

2.3.6 The Board will comply with regional and national reporting requirements of COVID-19 Engagement Boards.

3. Authority and Accountability
3.1 The Board has a responsibility to direct individual members will be able to act with the level of authority and the powers granted to them by way of their constituent bodies’ policies and make decisions on that basis. Its role is primarily one of engagement, oversight and collective co-ordination. It will have responsibility for political oversight of the local delivery of the plan and response and for communicating and engaging with residents and communities.

3.2 This Board will meet in public and be chaired by the Leader of Somerset County Council.

3.3 The Board Chair will actively seek to reach agreement by consensus on the recommendations for decision by the constituent members’ statutory bodies.
3.4 Should this not be possible then issues should be escalated to all member bodies’ boards/cabinet to attempt to find a resolution.

3.5 There may be times, particularly when there are outbreaks, for decisions to be taken quickly regarding communications, in instances where this is urgent it is proposed that all Board members will be notified via email of the decision and the decision is delegated to the Chair and Vice Chair of the Board in consultation with the Director of Public Health.

4. **Board Membership**

4.1 The Board will have a broad membership to include real engagement across Somerset’s geography and those communities particularly affected by COVID-19, such as older people, people with disabilities or long-term health conditions, the BAME community and the business community.

The Board shall be made up of the following members:

Core members to include:

- Leader of Somerset County Council - Chair
- Portfolio Holder for Public Health & Climate Change (Health & Wellbeing Board Chair) – Vice Chair
- Avon and Somerset Police and Crime Commissioner
- Chair, Somerset Clinical Commissioning Group
- CEO, Somerset County Council
- Director of Public Health, Somerset County Council
- One representative from Sedgemoor District Council
- One representative from Somerset West and Taunton Council
- One representative from South Somerset District Council
- One representative from Mendip District Council
- Representative from Somerset Business Sector
- Representative from Somerset Education Sector

4.2 The Board may co-opt members for meetings should significant outbreaks occur in specific settings, groups or geographies.

4.3 Members should make every effort to attend but may identify a named representative in their absence.
5. **Quorum**

5.1 A quorum will be reached with at least the Chair (or Vice Chair) and five members.

5.2 If the quorum has not been reached, then the meeting may proceed if those attending agree, but no recommendations for decision by the constituent member bodies may be taken.

5.3 Nominated deputies attending a meeting on behalf of a member may count towards the quorum.

6. **Notice and Frequency of Meeting**

6.1 Generally, meetings will be held Monthly but more frequently if required for specific matters.

6.2 An agenda specifying the business proposed to be transacted shall be delivered electronically to each member, save in the case of emergencies or the need to conduct urgent business.

6.3 The Board members may meet either in person, via telephone/video conference or communicate by email if an urgent recommendation for decision is required or if there is an urgent matter to discuss. The quorum, as described at section 5, must be adhered to for urgent meetings.

6.4 The Board will be formally recorded, and actions and notes will be provided to the members after each meeting.

7. **Review and Monitoring of Effectiveness**

7.1 The effectiveness of the Board shall be monitored at least annually through a review process that will include gathering the views of key individuals across the system.

7.2 The Board will review these terms of reference at least quarterly or more regularly in light of policy changes or changes in the needs resulting from the local epidemic.
Annex III: Somerset COVID-19 Health Protection Board Remit and Terms of Reference

1. Context
1.1 Local Authorities have a significant role to play in the identification and management of COVID-19 outbreaks. The purpose of Local Outbreak Management Plans is to give clarity on how local government works with the NHS Test and Trace Service to ensure a whole system approach to managing local outbreaks.

1.2 Building on the foundation of the statutory role of Director of Public Health, working with Public Health England’s local Health Protection Teams, the Local Outbreak Management Plan will provide the mechanism for local authorities to anticipate, prevent and contain incidents and outbreaks in their local area using their knowledge of and relationship with people and place. The Director of Public Health will be responsible for defining these measures working through the Somerset COVID-19 Health Protection Board.

2. Purpose
2.1 To Lead the delivery of the Local Outbreak Management Plan

2.2 To minimise the morbidity and mortality associated with COVID19 within Somerset.

3. Duties and Key Responsibilities
3.1 To oversee the delivery of the Local Outbreak Management Plan.

3.2 The Board will promote the close collaboration of the Somerset system, PHE and the Joint Biosecurity Centre to ensure better outcomes for residents in Somerset.

3.3 The Board will lead the local Public Health response to the epidemic, ensuring join up with Public Health England (and NHS Test and Trace) within Somerset to specific outbreaks and to the pandemic as a whole, taking decisions regarding how to respond under the led by the Director of Public Health.
To ensure a thorough understanding of the pandemic within Somerset at any one point of time through the effective use of data and intelligence, including on test and trace data, local outbreaks and intelligence, NHS and care providers capacity and mortality.

To mobilise resources as required to effectively respond to COVID outbreaks and control the local epidemic. To develop and maintain dataflows and communications amongst Somerset partner agencies in order to maintain an up to date position on the local epidemic.

Remain informed by the emerging national evidence base and evaluate the impact of local interventions, including public health messaging, to ensure effective use of resources.

To advise the COVID-19 Engagement Board on the provision of clear, evidence based messages to inform communication to the public.

To provide regular reports to the COVID-19 Engagement Board on the tracking of the local epidemic and the high-level position of open outbreaks.

To escalate issues affecting either the Somerset system or residents, to regional Strategic Coordination Group, to enable resolution of issues within nationally commissioned programmes.

To understand the triggers for a major incident and ensure timely decision making to enable requests for mutual aid to be made, or where cross border issues are impacting the Somerset system, liaise with the LRF to declare a Major Incident should this be required.

Comply with regional and national reporting requirements.

To use opportunities for reflection to review resilience within the system and use the learning in preparation for future outbreaks.

To receive and review escalation reports from cells; IPC, PPE, Care Sector, Vaccination, Vulnerable People and Community Resilience, and Workforce Development / Pastoral Care.
4. **Authority and Accountability**

4.1 The Board has no executive powers however individual members will be able to act with the level of authority and the powers granted to them by way of their constituent bodies' policies and make decisions on that basis. Notwithstanding and for the avoidance of doubt, the Board is not a decision-making body but is able to discuss and agree recommendations for approval by the constituent members’ statutory bodies; its role is primarily one of epidemic oversight, and collective co-ordination.

4.2 The Board Chair will actively seek to reach agreement by consensus on the recommendations for decision by the constituent members’ statutory bodies. Should this not be possible then issues should be escalated to all member bodies’ boards/cabinet to attempt to find a resolution.

4.3 The Board will provide advice and recommendation on the use of local COVID19 powers but will defer to the Chair where an emergency decision is required.

5. **Way of Working (WOW)**

5.1 Notice and Frequency of Meeting:
- Generally, meetings will be held weekly but more frequently if required for specific matters.
- An agenda specifying the business proposed to be transacted shall be delivered electronically to each member, save in the case of emergencies or the need to conduct urgent business.
- The Board members may meet either in person, via telephone/video conference or communicate by email if an urgent recommendation for decision is required or if there is an urgent matter to discuss. The quorum, as described at 5.5, must be adhered to for urgent meetings.
- The Board will be formally recorded, and actions and notes will be provided to the members after each meeting.

5.2 Fixed agenda to include:
- Epidemiological review Somerset
- Relevant local and national updates and requests for action
- Cell progress updates & escalated issues
- Strategic Risks
• Actions / Decisions

5.3 For each meeting:
• Agenda and associated documents and live RAIDL will be circulated to members prior to each meeting
• Notes and actions will be circulated on the same day of the meeting
• Key messages will be agreed to pass to the Communications Cell to progress in line with their Covid communications group protocol

5.4 Quorum:
• A quorum will be reached with at least the Chair and four of the core members.
• If the quorum has not been reached, then the meeting may proceed if those attending agree, but no recommendations for decision by the constituent member bodies may be taken.
• Nominated deputies attending a meeting on behalf of a member may count towards the quorum.

5.5 Review and Monitoring of Effectiveness:
• The effectiveness of the Board shall be monitored at least annually through a review process that will include gathering the views of key individuals across the system.
• The Board will review these terms of reference at least quarterly or more regularly in light of policy changes or changes in the needs resulting from the local epidemic.

6. Outputs:
6.1 Accept escalations / requests for action from and to the Health and Social Care Tactical Silver Group and relevant operational cells

6.2 RAIDL

6.3 Strategic Risks and mitigations

6.4 Gaps in provision and future requirements are identified and captured

6.5 Subject Matter Experts share crucial information for the effective management of the epidemic
6.6 Agree joint communications opportunities as appropriate

7. **Members:**

7.1 The Board shall be made up of the following members: Core members to include:

- Director of Public Health, Somerset County Council – Chair
- Director of Adult Social Care, Somerset County Council
- Consultant in Communicable Disease - Public Health England
- Director of Infection Prevention & Control, Somerset Clinical Commissioning Group
- Clinical Director - Somerset Clinical Commissioning Group
- Medical Director - Somerset Foundation Trust
- Medical Director - Yeovil NHS Foundation Trust

7.2 Additional members / members ion attendance, as required:

- Wing Commander, Military planning and liaison team, Avon and Somerset
- Mendip District Council – Environmental Health Principal
- Environmental Health Principal - Sedgemoor District Council
- Environmental Health Principal - South Somerset District Council
- Environmental Health Principal - Somerset West & Taunton District Council

7.3 Additional support provided to the Board:

- Public Health Consultant – Health Protection
- Public Health Consultant – Public Health Intelligence
- Business Change Project and Change Manager – Somerset County Council

7.4 Members should make every effort to attend but may identify a named representative in their absence.

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chair and Deputy Chair</strong></td>
<td>• Co-ordinates key updates and provides vision/steer</td>
</tr>
<tr>
<td></td>
<td>• Ensures effective information sharing and feedback Tactical Group and Cells</td>
</tr>
<tr>
<td></td>
<td>• Clarifies actions, and ensures that risks, owners and actions are captured appropriately</td>
</tr>
<tr>
<td><strong>Business Change</strong></td>
<td>• Co-ordinates the reporting from the Cells and ensures deadlines for Dashboards are communicated.</td>
</tr>
</tbody>
</table>
• Provide assurance around the capture of issues; risks; actions; key learning
• Creates and effective feedback loop for the completion of actions and decisions made
• Helps to coordinate to development and management of the cells and the governance process for the system

| Cell Leads (non-members) | • Escalate issues from Workstreams  
| | • Provide summary updates on Workstream activity as and when required  
| | • Identify opportunities for Multi-Agency support and information sharing |

| Risk Lead (non-member) | • Compile and maintain a Strategic Risk Register  
| | • Provide updates at every meeting, advising on mitigations and escalation requirements |

| Business Support (non-member) | • Record meeting notes and actions.  
| | • Capture and input emerging risks, actions and relevant detail on the RAIDL. |

| All Members | responsible for checking RAIDL frequently and ensuring key updates are ready prior to meetings |
Annex IV: Example of the COVID-19 Public Dashboard

Somerset COVID-19 Local Outbreak Management Plan Dashboard - 04/03/2021

Detected cases

19105

Latest 7 day rate per 100k
22-Feb to 28-Feb

46.8

Most recent days of cases

Overall profile of the epidemic in Somerset

Somerset pillars 1&2 confirmed COVID cases daily

Test results not usually reported publicly for three days from specimen date.

Produced 03/03/2021 For data sources see final page For more information contact publichealth@somerset.gov.uk
### Somerset COVID-19 Local Outbreak Management Plan Dashboard - Cases

Weekly cases (excludes most recent three days with incompletely reported results)

<table>
<thead>
<tr>
<th>District</th>
<th>01-Feb to 07-Feb</th>
<th>7 day rate per 100k</th>
<th>08-Feb to 14-Feb</th>
<th>7 day rate per 100k</th>
<th>15-Feb to 21-Feb</th>
<th>7 day rate per 100k</th>
<th>22-Feb to 28-Feb</th>
<th>7 day rate per 100k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mendip</td>
<td>112</td>
<td>96.9</td>
<td>78</td>
<td>67.5</td>
<td>81</td>
<td>70.1</td>
<td>52</td>
<td>45.0</td>
</tr>
<tr>
<td>Sedgemoor</td>
<td>206</td>
<td>167.2</td>
<td>138</td>
<td>112.0</td>
<td>146</td>
<td>118.5</td>
<td>90</td>
<td>73.1</td>
</tr>
<tr>
<td>Som W &amp; Taun.</td>
<td>260</td>
<td>167.6</td>
<td>141</td>
<td>90.9</td>
<td>96</td>
<td>61.9</td>
<td>59</td>
<td>38.0</td>
</tr>
<tr>
<td>Sth Somerset</td>
<td>187</td>
<td>111.1</td>
<td>99</td>
<td>58.8</td>
<td>111</td>
<td>65.9</td>
<td>62</td>
<td>36.8</td>
</tr>
<tr>
<td>Somerset</td>
<td>765</td>
<td>136.1</td>
<td>456</td>
<td>81.1</td>
<td>434</td>
<td>77.2</td>
<td>263</td>
<td>46.8</td>
</tr>
</tbody>
</table>

Produced 03/03/2021. For data sources see final page. For more information contact publichealth@somerset.gov.uk
Date range 22-Feb to 28-Feb

March 2021 - we have updated the colour scheme to reflect the new lower case numbers.

The numbers in this map show the current cases in the past 7 days, the colour of the tag shows the equivalent rate of positive cases per 100,000 population over a 7 day period. Case numbers in Taunton, Wellington, Chard, Yeovil, Bridgwater and Frome have been combined across the urban area with rates based on the combined area population.
Somerset COVID-19 Local Outbreak Management Plan Dashboard - Wider Context

Latest R number range for the South West

0.6 - 0.8

Last updated on Friday 26 Feb 2021

Produced by:

UK Government Scientific Advisory Group for Emergencies (SAGE)

What is R?
The reproduction number (R) is the average number of secondary infections produced by 1 infected person.

An R number of 1 means that on average every person who is infected will infect 1 other person, meaning the total number of new infections is stable.

<table>
<thead>
<tr>
<th>Region</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>0.6 - 0.9</td>
</tr>
<tr>
<td>England</td>
<td>0.7 - 0.9</td>
</tr>
<tr>
<td>East of England</td>
<td>0.6 - 0.8</td>
</tr>
<tr>
<td>London</td>
<td>0.6 - 0.8</td>
</tr>
<tr>
<td>Midlands</td>
<td>0.7 - 0.9</td>
</tr>
<tr>
<td>NE and Yorks</td>
<td>0.7 - 0.9</td>
</tr>
<tr>
<td>North West</td>
<td>0.7 - 0.9</td>
</tr>
<tr>
<td>South East</td>
<td>0.7 - 0.9</td>
</tr>
<tr>
<td>South West</td>
<td>0.6 - 0.8</td>
</tr>
</tbody>
</table>

Produced 03/03/2021 For data sources see final page For more information contact publichealth@somerset.gov.uk
Somerset COVID-19 Local Outbreak Management Plan Dashboard - District focus

Daily detected cases pillars 1&2 (Lab confirmed) per 100k pop. 7 day rate

- Mendip
- Sedgemoor
- Som. W&T
- S. Som.
- Somerset
- South West

Test results not usually reported publicly for three days from specimen date.

Pillar 2 Tests per 100k population last 7 days

- Somerset: 5,514
- Mendip: 5,082
- Sedgemoor: 6,136
- Somerset West and Taunton: 6,654
- South Somerset: 5,921

Daily detected cases pillars 1&2 (Lab confirmed) per 100k pop. 7 day rates

District COVID deaths (ONS data)

19/02/2021 Total deaths

- Mendip: 177
- Sedgemoor: 174
- S. W&T: 216
- S. Som.: 183

Place of death breakdown

- Elsewhere
- Care home
- Home
- Hospice
- Hospital
- Other communal establishment

Produced 03/03/2021. For data sources see final page. For more information contact publichealth@somerset.gov.uk
Somerset COVID-19 Local Outbreak Management Plan Dashboard - COVID Vaccinations

This page will be further developed once there is more routinely available data published nationally.

This vaccination data is NHS data, reported here with the agreement of the Somerset Clinical Commissioning Group. Specific queries regarding vaccination need to be directed towards the NHS. For more information on the local COVID-19 Vaccination Programme please see Covid-19 vaccinations in Somerset - Somerset CCG

Population numbers are based on ONS 2019 estimates hence potential for uptake over 100%.
## Somerset COVID-19 Local Outbreak Management Plan Dashboard - Data

<table>
<thead>
<tr>
<th>Data type</th>
<th>Next updated</th>
<th>How published</th>
<th>Link for more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab confirmed cases pillars 1 &amp; 2</td>
<td>04/03/2021</td>
<td>Published daily ~5pm with data to day before. By specimen date.</td>
<td><a href="https://coronavirus.data.gov.uk/">https://coronavirus.data.gov.uk/</a></td>
</tr>
<tr>
<td>Data by MSOA for the map</td>
<td>04/03/2021</td>
<td>Published daily. By specimen date.</td>
<td>None. Not publicly distributed. Data based on PHE reported cases. To note, this may differ slightly from data on the coronavirus.data.gov.uk website due to additional data cleaning by PHE.</td>
</tr>
<tr>
<td>R value from SAGE group</td>
<td>05/03/2021</td>
<td>Published weekly on Friday.</td>
<td><a href="https://www.gov.uk/guidance/the-r-number-in-the-uk">https://www.gov.uk/guidance/the-r-number-in-the-uk</a></td>
</tr>
<tr>
<td>Pillar 2 testing</td>
<td>09/03/2021</td>
<td>Summarised weekly on Wednesdays and Thursdays</td>
<td>None. Not publicly distributed.</td>
</tr>
<tr>
<td>Death counts (ONS) county and district level</td>
<td>09/03/2021</td>
<td>Published weekly on Tuesday with data to the Friday 11 days before.</td>
<td><a href="https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard">https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard</a></td>
</tr>
</tbody>
</table>

As of 2nd June 2020, numbers of lab-confirmed positive cases now include those identified by testing in all settings (pillars 1 and 2).

NB The higher case numbers seen in early June include a number of cases that have been falsely identified as positive following an issue at the laboratory. For further information please see the following statement from Somerset NHS Foundation Trust [https://somersetft.nhs.uk/?news=issue-affecting-some-covid-19-test-results-for-some-inpatients-at-musgrove-park-hospital](https://somersetft.nhs.uk/?news=issue-affecting-some-covid-19-test-results-for-some-inpatients-at-musgrove-park-hospital).

In January 2021, we changed the presentation of deaths data to be shown compared to the average and five year high and low deaths by date of occurrence rather than date of reporting. Deaths by date of reporting fluctuates more, especially when affected by bank holidays. Reporting by date of death does mean the latest week’s figures are usually slightly incomplete when first reported due to delays in registrations of some deaths whereas the comparison years are more complete. For week 53 we have taken an average of 52 and week 1 comparison years.


56
Annex V: Definition of an Outbreak

Context
1. With lockdown being eased, this paper provides an overview of definitions that PHE would use as part of its daily submission to the JBC and ongoing monitoring of COVID-19 in different settings.

2. It focuses on outbreak definitions in key settings, prioritising those that are critical for local and national infrastructure and areas with significant public and press interest. Applied to surveillance data shared with the Joint Biosecurity Centre, these definitions will inform local alerts and action and provide consistency with how areas manage outbreaks.

Priority settings for the JBC
3. On this basis, the following categories have been prioritised:
   - Local settings: schools, nurseries, cafes, restaurants and bars, religious and factory settings
   - Sport and leisure industries
   - National Infrastructure: Police, Fire, Finance, Transportation and Parliamentary settings
   - International jurisdictions
   - NHS and healthcare facilities
   - Institutional and residential settings e.g., prisons, care homes, boarding schools.

Outbreak definition for non-residential settings
4. Table 1 provides the definition of an outbreak in non-residential settings and also includes the criteria to measure recovery and declare the end of an outbreak. This definition is consistent with the WHO outbreak definition.

5. A cluster definition is also provided to capture situations where there is less epidemiological evidence for transmission within the setting itself and there may be alternative sources of infection; however, these clusters would trigger further investigation.
Table 1: Declaring and ending an outbreak and cluster in a non-residential setting (e.g. a workplace, local settings such as schools and national infrastructure)

<table>
<thead>
<tr>
<th>Criteria to declare</th>
<th>Criteria to end</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cluster</strong></td>
<td></td>
</tr>
<tr>
<td>Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days</td>
<td>No confirmed cases with onset dates in the last 14 days</td>
</tr>
<tr>
<td>(In the absence of available information about exposure between the index case and other cases)</td>
<td></td>
</tr>
<tr>
<td><strong>Outbreak</strong></td>
<td></td>
</tr>
<tr>
<td>Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days</td>
<td>No confirmed cases with onset dates in the last 28 days in that setting (higher threshold for outbreaks compared to clusters)</td>
</tr>
<tr>
<td>AND ONE OF:</td>
<td></td>
</tr>
<tr>
<td>Identified direct exposure between at least two of the confirmed cases in that setting (e.g., within 2 metres for &gt;15 minutes) during the infectious period of the putative index case</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>(when there is no sustained community transmission or equivalent JBC risk level) - absence of alternative source of infection outside the setting for initially identified cases</td>
<td></td>
</tr>
</tbody>
</table>

6. Table 2 provides a broader definition of an outbreak in residential settings. This definition differs from the definition for non-residential settings because SARS CoV2 is known to spread more readily in residential settings, such as care homes and places of detention, therefore a cluster definition is not required.
Table 2: Declaring and ending an outbreak and cluster in an institutional or residential setting, such as a care home or place of detention

<table>
<thead>
<tr>
<th>Criteria to declare</th>
<th>Criteria to end</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outbreak</strong></td>
<td></td>
</tr>
<tr>
<td>Two or more confirmed cases of COVID-19 OR clinically suspected cases of COVDI-19 among individuals associated with a specific setting with onset dates within 14 days</td>
<td></td>
</tr>
<tr>
<td>NB. If there is a single laboratory confirmed case, this would initiate further investigation and risk assessment.</td>
<td>No confirmed cases with onset dates in the last 28 days in that setting</td>
</tr>
</tbody>
</table>

Table 3: Declaring and ending an outbreak and cluster in an inpatient setting such as a hospital ward or ambulatory healthcare services, including primary care

<table>
<thead>
<tr>
<th>Criteria to declare</th>
<th>Criteria to end</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outbreak in an inpatient setting</strong></td>
<td></td>
</tr>
<tr>
<td>Two or more confirmed cases of COVID-19 OR clinically suspected cases of COVDI-19 among individuals associated with a specific setting with onset dates 8-14 days after admissions within the same ward or wing of a hospital.</td>
<td></td>
</tr>
<tr>
<td>NB. If there is a single laboratory confirmed case, this would initiate further investigation and risk assessment.</td>
<td>No confirmed cases with onset dates in the last 28 days in that setting (higher threshold for outbreaks compared to clusters)</td>
</tr>
</tbody>
</table>

| **Outbreak in an outpatient setting** |                 |
| Two or more confirmed cases of COVID-19 among individuals associated with a specific setting with onset dates within 14 days |
| AND ONE OF: |
| Identified direct exposure between at least two of the confirmed cases in that setting (e.g., within 2 metres for >15 minutes) during the infectious period of the putative index case |
| OR |
| (when there is no sustained community transmission or equivalent JBC risk level) - absence of alternative source of infection outside the setting for initially identified cases | No confirmed cases with onset dates in the last 28 days in that setting |
Protocols for managing outbreaks and incidents with multiple agencies

7. There are existing multiagency incident management protocols in place for managing complex incidents. These are led by local Health Protection Teams in collaboration with the relevant partner agencies for setting in question.

8. In addition, local government is also providing support on identifying and managing outbreaks with advice and support on guidance, infection prevention control, cleaning and social distancing for schools, nurseries and care home settings.

9. For complex outbreaks multiagency meetings are co-ordinated in the following situations:
   1. there has been a death in the setting
   2. there are a large number of vulnerable people
   3. there are a high number of cases
   4. the outbreak has been ongoing despite usual control and infection control measures
   5. there are concerns on the safe running of the setting or institution
   6. there are other factors that require multi-agency coordination and decision making
Annex VI: COVID-19 Communications and Engagement Plan

1. Introduction

As set out in Somerset’s Local Outbreak Management Plan, ongoing engagement and communication with local residents, visitors, businesses and communities is paramount to controlling the spread of infection. This will be achieved through promoting national, local and public health messages and reacting quickly when an outbreak occurs.

Somerset’s coronavirus cases have risen in line with what has been seen across the UK. In the latter part of 2020, the County saw rates-per 100,000 rising rapidly in line with other parts of the UK nationally. The latest national lockdown and roll out of the vaccination programme has had a positive impact on case numbers. Nationally and locally, we are seeing rates fall and case numbers decreasing.

As the vaccination programme continues to gather pace, we still adhering to government guidelines including staying at home as much as possible, following Hands Face Space and guidelines around testing and isolating. This is crucial as we do not yet know how the vaccination affects transmission – even after being vaccinated it is still possible to catch the virus and or pass it to others.

As well as the national PCR and LFT testing, locally, a mass community testing programme is now in place. The strategy for this is the ‘test to protect’ model where the tests are being focussed specifically by invite only to people that cannot work from home and who work with the most vulnerable groups in our communities.

Rapid and effective communications is recognised by the government’s Joint Biosecurity Centre (JBC) as a primary intervention for controlling the spread of the virus.

2. Aims

The aims of this Communications Strategy are to:

- Engage and communicate with Somerset residents, visitors to the County, businesses, employers and communities to encourage them to behave responsibly, follow national, local and public health guidelines and prevent further infection.
• Dispel common vaccination myths and encourage people to step forward for the vaccination when it is their turn. Whilst reinforcing the important message of not contacting GPs, the NHS will contact you when it is your turn for vaccination.

• Ensure audiences are fully aware of the importance of sticking to the guidance around infection protection control (HANDS FACE SPACE) as it is still not clear the effect of vaccination on transmissibility – you can still catch the virus and may still pass it on.

• Promote the importance of the national and local test and trace service if residents start to show Coronavirus symptoms. Encourage take-up, showcase how and why tracing works, provide reassurance and explain how sharing close contacts will prevent the spread of the virus and save lives.

• Raise awareness and encourage residents and visitors (or anyone in their household) experiencing Coronavirus symptoms to immediately self-isolate, securing buy-in from communities and employers and signposting those affected to available support. Ensure that it’s clear that the whole household must isolate for the full ten days if one member of the household tests positive, or if symptomatic until a negative test result has been received.

• Communicate with relevant stakeholders when clusters/outbreaks occur in community settings (workplace, schools, housing complexes, care homes etc) and communicate potential measures which may have to take place in order to prevent further spread.

• Work closely with health, care, education and childcare, public sector, VCSE and other key partners to collectively promote messages and engage with Somerset communities in order to maximise reach.

This Strategy will complement and use (but not replace) other local and national coronavirus-linked communications campaigns. These include the national government guideline campaigns, NHS and other national campaigns for example; symptoms, testing, vaccination, social distancing and handwashing campaigns.

3. Governance – the role of the COVID-19 Engagement Board

This communications strategy has been agreed by and will be evaluated by the local COVID-19 Engagement Board.

The Engagement Board will provide a useful forum to agree and co-ordinate the sharing of key messages across a range of sectors including health, education, public transport, culture, tourism, communities, businesses, and the third sector.
The board will support the aims of the Communications Strategy through their own networks and resources. Members of the Board should take an active role in cascading key messages to their organisation’s employees, networks and customers.

Stemming from the engagement board, a Health and Wellbeing Advisory Network made up of a range of organisations and groups will provide a mechanism for two-way communication and aid the management of the local epidemic and improve the health and wellbeing of the public.

The Network will help us to understand the COVID-19 related communication and engagement needs of our communities across Somerset, especially our more vulnerable groups. The Network will provide a platform for a two-way dialogue that can be fed back to the COVID-19 Engagement Board to help shape our response to the pandemic. It will allow both preventative and reactive conversations with a number of settings and groups where an outbreak of COVID-19 is likely to have adverse health consequences.

4. Stakeholders

A co-ordinated multi-agency approach will be needed across a range of stakeholders including local and national government, the NHS, care sector, education, businesses, voluntary organisations and other community partners, media and the general public to successfully deliver this Communications Strategy.

If clusters/outbreaks are identified in specific settings, further stakeholders may need to be identified on a local basis.

The Joint Biosecurity Centre has identified a number of settings and sub-settings, which should all be considered as part of our stakeholder engagement. Please note this list should not be considered final.

5. Key messages

Our communications must be meaningful, open, transparent with an emphasis on social responsibility. Behaviour is the key to reducing infections.

Messages therefore need to connect and resonate with audiences, shape their behaviour through reminding residents and visitors of the importance of social responsibility, the
consequences if they do not with a ‘we all need to play our part’ to reduce the spread and save lives.

6. Strategy

6.1 Engage and communicate with Somerset communities to reduce infection

National messages are widespread (TV, newspaper, radio and digital advertising) on promoting Coronavirus symptoms; the importance of reducing infection through social distancing, frequent washing of hands and keeping distance from others; self-isolating if you or someone in your household start to show symptoms; and the national and local test and trace.

This Communications Strategy will complement the national campaign through sharing DHSC and PHE social media messages (a trusted source) - reinforcing national messages through local communication avenues including press and media, digital engagement, direct marketing, identifying influencers, creating communication toolkits, internal communications and publications.

It will also be key to develop our own localised messages based on where we are seeing particular issues that are impacting infection rates, where possible, messaging and campaigns will be based on the com b model which highlights three key factors that must change in order for behaviour change to occur: capability, opportunity and motivation.

Localised messaging tends to resonate with audiences in a more personal way as often audience ‘switch off’ to Government guidance. Nationally, translated materials either come out much later than the guidance itself or isn’t applicable to the ethnic groups within or society. SCC will develop materials as needed to reinforce key messages with these groups.

Existing communication avenues will be used to promote key public health messages including staff forums, Covid Community Champions, Talking Cafes, local social media, community groups, GP surgeries, Your Somerset, e-newsletters, Engagement Board stakeholder update, our Somerset Covid Catch up, the Advisory Network and more besides.
Work will continue with evidence based ‘higher risk’ areas such as workplaces, care homes, businesses, schools, faith centres, tourism and hospitality sites to ensure everyone behaves in a safe and appropriate manner, are aware of and can access latest government guidance and knows what to do if someone within their establishment develops COVID-19 symptoms.

A Public Health Dashboard is published daily at www.somerset.gov.uk/coronavirus, which enables residents, visitors, businesses and communities to see the latest Coronavirus Somerset figures and helps dispel myths. This supports Somerset residents to make informed decisions and potentially shape behaviour. This gets shared weekly through social media as well as on the www.somerset.gov.uk/coronavirus website.

6.2 Testing

Testing for coronavirus is currently split between two programmes – symptomatic (for those with symptoms of coronavirus) and asymptomatic (for those who do not have symptoms or who are pre-symptomatic).

**Symptomatic Testing**

Residents can get a free NHS test if they are displaying any of the following symptoms:

- a high temperature
- a new continuous cough
- a loss of or change to your sense of smell or taste

The test must be done in the first five days of having symptom, and a test must be booked online or by phoning 119.

**Asymptomatic Testing**

Around one in three people with coronavirus do not have symptoms. Lateral flow testing is a fast and simple way to test people who do not have symptoms, but who may still be spreading the virus.

Lateral flow testing involves a swab of the nose and throat to collect a sample and provides a result within around half an hour. This screening test requires twice weekly testing.

In Somerset targeted community testing is already in place for workers who care for vulnerable groups such as the elderly in their own homes. This testing sits alongside the
multitude of national testing programmes. On 10 January 2021 central government announced that a community testing offer using lateral flow devices, was to be expanded across all local authorities in England to test people without symptoms of coronavirus (COVID-19).

Somerset is adopting a phased approach which is designed to reach those in close contact with the most vulnerable first. Therefore, at present, appointments are by invitation only. We continue to expand this community testing programme to more groups.

Other groups covered by centrally co-ordinated asymptomatic testing programmes are:

- Businesses
- Care home residents and staff
- Care home visitors
- School children and staff
- NHS and social care workers
- Households and bubbles of school pupils and staff
- University students
- Personal Assistants
- Patients being admitted to hospital

6.3 Vaccination

Following extensive safety trials and authorisation by the independent medicines’ regulator, the MHRA, effective COVID-19 vaccines are now available in the UK for free. The success of the vaccination rollout is one of the key tests that will pave the way for the safe and gradual lifting of restrictions.

So far, more than 18.6 million people have been vaccinated and the DHSC has announced they met their target for the first phase of the rollout, the first dose of the vaccine will now be offered to the remaining JCVI cohorts - all those aged 50 and over or in a higher risk group - by 15th April.

DHSC has announced that they then expect to offer a first dose to all remaining adults by 31st July.

Everyone in the top four priority groups – eligible care home residents and staff, those aged over 80, frontline health and social care staff, those aged over 70, and the clinically
extremely vulnerable – has now been offered a vaccination. Anyone in these groups who has not yet had their vaccine is asked to call the national booking service or go online and arrange their appointment.

NHS staff are now vaccinating people in cohorts 5 and 6 - that's people aged 65 to 69 and those who are clinically vulnerable against Covid, together with carers and young adults in residential settings.

6.4 Test and Trace

The Government Communication Service (GCS) has launched a national campaign alongside the NHS Test and Trace programme based around the themes of: “Test. Trace. Contain. Enable.”

The NHS Test, Trace, Contain and Enable service forms a central part of the government’s COVID-19 recovery strategy, which seeks to return life to as close to normal as possible, for as many people as possible, in a way that is safe and protects the NHS and social care. If an employee, client / service user, resident or visitor tests positive for COVID-19, the NHS Test, Trace, Contain and Enable service will help to identify people at high risk of having been exposed to the virus through recent close contact. It will alert those contacts who meet defined risk criteria, based on the proximity and duration of the contact they’ve had, and provide advice on what steps to take. This will include being informed to self-isolate or in certain circumstances require contacts to be tested.

If contact tracing and subsequent testing identifies two or more cases of COVID-19 from a specific workplace or setting, the NHS Test, Trace, Contain and Enable service will activate the outbreak notification process. An assessment will be made by Public Health England who will escalate for information, or for action. Details of the outbreak will be forwarded to the Infection Prevention and Control Team and the Public Health Incident Room, where appropriate actions are taken.

This Strategy will:

- Promote the importance of the national Test, Trace, Contain and Enable service if residents/visitors start to show Coronavirus symptoms in preventing further community spread through promoting national and locally tailored messages with the aim to encourage take up.
- Explain how the tracing system works to individuals and employers and how it will help to reduce the spread of the virus.
• Encourage relevant businesses to take customers contact details in a safe and secure way in order to support the test and trace system and helping save lives.
• Encourage people to ‘play their part’ by using the tracing system if testing positive and addressing any barriers to participation.
• Raise awareness that individuals may be contacted by NHS Test, Trace Contain and Enable service and should follow instructions given. self-isolate.
• Raise awareness of proactive advice and guidance, ensuring it’s easily available
• Promote guidance for identified settings such as schools, workplaces, care homes, businesses etc, again ensuring it is easily available.

6.5 Self-isolate if showing symptoms

This Strategy will continue to encourage Somerset residents and visitors to play their part and self-isolate for ten days if they or someone in their household start to show symptoms and book a test (available to anyone aged 5 and above).

It will also promote the importance to self-isolate immediately for ten days if you are contacted by the ‘test and trace service’ and advised you’ve been in close contact with someone who tests positive.

Work will continue with settings (schools, care homes, businesses etc) to ensure they are aware what to do if someone in their establishment shows symptoms including promoting national guidance and infection prevention advice.

This Strategy will also promote support available for people self-isolating who may feel anxious and concerned. Support includes promoting the single helpline: 0300 790 6275, Mindline: 01823 276892, volunteer networks, Covid champions, home schooling and childcare tips, financial support, the bereavement support service and the Healthy Somerset website which has a host of useful information and resources around a number of public health topics.

It will also:
• Encourage individuals to prepare in advance for self-isolation by understanding what support is available and consider how they would get food, medicine, etc;
• Communicate that self-isolation means to leaving home at all, not for exercise or shopping, you must stay home
• Encourage individuals to ‘play their part’ by supporting their friends, family and neighbours in isolation.
• Encourage employers to ‘play their part’ by preparing in advance for employees self-isolating by clarifying policies, processes and support available.

6.6 Outbreaks in settings

Somerset’s Local Outbreak Management Plan specifically highlights clusters/outbreaks are more likely to occur in care homes, schools, high risk workplaces, community settings and locations – places where people are more likely to congregate and socially distancing measures are more likely to break down or not be possible.

Local authorities and their partners will need to make use of their local and well-networked position to target messaging and reach specific communities and employers if an outbreak/cluster occurs in a particular setting or area.

EHO’s will play a vital part in supporting workplaces with information, guidance and enforcement.

This strategy proposes the following phased approach if Somerset has a cluster/outbreak:

Phase 1 – notification of a local outbreak
Identify stakeholders affected by the outbreak and decide best approach to contact them e.g., Headteacher letter to parents.

Reassure stakeholders whilst explaining the situation, advise what infection control measures are in place (e.g., no visitors allowed, school closing etc), promote awareness of symptoms and the test and trace service.

Explain what conditions will need to be met for any new measures to be eased.

Encourage those shielding to be extra cautious and abide by public health advice.

Educate about the potential consequences of not complying and thank those who are doing the right thing.

Encourage key outbreak influencers (i.e. school leaders, care home managers, employers, Cllrs) to ‘play their part’ by sharing messaging with their own contacts.
As these aims and messages will be very specific to local conditions, it is recommended messaging is seen to be led locally. However, this should link to national guidance and messages. Most importantly, it must be able to be deployed quickly.

For residents who do not speak English messaging needs to be accessible. Consider translation of key messages into both text and audio-visual materials. Empower local communities to share these messages ‘on the ground’ by producing translated resources that can be shared by key influencers and by working closely with local communities. Ensure any visuals represent the diversity of communities.

A communications toolkit will be devised as part of this Strategy including stakeholder checklists, reactive statements, sample letters, digital collateral – which can be amended and adapted quickly to support getting communications out quickly.

**Phase 2 – the end of a local outbreak**

Where necessary, this phase can support the ‘recovery’ of a particular area/setting if needed, with aims to:

- Promote any changes to the guidelines or restrictions to identified key stakeholders.
- Explain the public health reasons behind why restrictions are being eased.
- Encourage residents to ‘play their part’ by supporting and engaging with local businesses and neighbours that may have been affected by restrictions.
- Explain how COVID-19 is being monitored across Somerset to protect public health.
- Continue to promote key public health messages i.e. social distancing, washing hands etc.
- Consider additional support messages may be required i.e., Mindline, bereavement support services etc.

**7. Implementation**

Since the onset of the pandemic, a range of local communication tools have been used to share and amplify national Department for Health and Social Care (DHSC) and Public Health England (PHE) messages around social distancing, test and trace, self-isolating, vaccination programme, testing programme etc.

This approach will continue. In addition, the following will be used to achieve the aims of this Communications Strategy:
7.1 Stakeholder engagement

Stakeholder engagement will be critical for successful delivery of this strategy, given the large number of distinct settings and audiences who may be difficult to engage with otherwise.

The Engagement Board will work closely with stakeholder representatives and oversee and discuss the communications and recovery plans. Each of these representatives have a key role to play in cascading feedback and information both to and from the board.

A multi-agency communications approach is also vital to the success of this Communications Strategy.

Somerset’s communications health, care and public sector teams already work closely together and meet virtually on a weekly basis – and can be ‘stepped up’ as required if a local outbreak occurs.

Messages will continue to be shared and disseminated to staff, businesses and communities through our partners communication channels.

Additionally, Somerset has a number of multi-agency command and control groups including the Avon and Somerset Local Resilience Forum (ASLRF), leaders from the five Local Authorities, our health and care system, emergency services, VCSE and Local Economic Partnership. These groups should be used to cascade key messages and resources.

7.2 Health and Wellbeing Advisory Network

The Health and Wellbeing Advisory Network will provide the mechanism by which the COVID Engagement Board and the Health and Wellbeing Board are able to understand the COVID related communication and engagement needs of our communities; for example, the barriers that may exist for social distancing, self-isolation, testing and being a contact to a positive case.

It will be the mechanism, by which to develop both preventative and reactive conversations with a number of settings and groups where an outbreak of COVID-19 is likely to have adverse health consequences. For example, homeless people hostels,
businesses that have a high proportion of workers who are not engaged with local health services, or where social distancing is challenging, or where there are a number of vulnerable individuals.”

7.3 Covid Community Champions

Covid community champions are one element of the Health and Wellbeing Advisory Network of the COVID-19 Engagement Board. Covid champions have been used in other parts of the country to assist in community engagement. For example, in Newham. This model is based on a mass recruitment to disseminate information and guidance. Covid Champions will work on two levels:

- Volunteers from identified community groups and settings, including identified workplaces.
- Volunteers throughout the community, including existing volunteers and health champions.

Covid champions will receive and provide information to and from their community / setting. They will also provide leadership within their community / setting to enact changes to prevent and control outbreaks if the needs arise.

7.3.1 Targeted Champions

Target groups are determined by national and local learning. It has been observed nationally that food processing facilities present higher rates of transmission and the opportunity for outbreaks to occur. Regionally we have noted higher rates of transmission in speakers of other languages. We are also aware of the higher rates of transmission and poorer outcomes from COVID-19 in groups that are already disadvantaged.

**Target groups will include but not limited to:**
- Gypsy, Traveller and Nomadic communities
- Groups of national origin
- Groups of ethnic origin
- Faith groups

**Target settings will include but are not limited to:**
- Food processing workplaces
- Manufacturing workplaces
• Houses of multiple occupation or communal living arrangements

7.3.2 Wider community champions

The wider pool of Covid champions (not those in identified targeted groups or settings) are likely to be those already active in their communities. This may be as part of the existing COVID-19 volunteer groups.

7.4 Press and media

The media play a key role in amplifying communications to a broader audience. Community and local media can also be used to reach priority audiences. As an overview we should:

• Regularly promote the work of the COVID-19 Engagement Board through press releases, press calls, conferences and other media opportunities. These should include mainstream, regional, and community or hyperlocal media as appropriate, particularly around local outbreaks.
• Continue to use trusted experts for quotes and interviews, especially the chair of the Engagement Board and sector-appropriate leaders, depending on the nature of campaigns or outbreaks.
• Media work to be underpinned by the key messages and the transparent and regularly sharing and signposting of as much local (and officially approved) public health data as possible.
• Reactively, organisational and system wide media protocols are in place for media handling and enquiries should be escalated to DsPH, Public Health England, NHSE&I and/or government bodies where necessary and appropriate.

7.5 Digital engagement

Digital engagement can be deployed quickly, is relatively cost-effective and has the potential of reaching a number of residents including those at home or self-isolating. We should continue to:

Share our own key messages through corporate social media channels of the council and key partners. These are trusted and have large established followings. We should use images, infographics, animations, blogs, Vlogs and videos as much as possible.
Amplify the reach of these messages by encouraging all corporate accounts, partners, members, and local MPs to re-share a selection of these posts.

In the event of an outbreak, it can also be targeted at particular audiences and geographies through paid social media boosting. Target social media messages with specific areas or audiences by encouraging specific influencers to share, using paid ads, and by sharing in local groups on Facebook, Twitter and NextDoor. The Director of Public Health and/or other appropriate spokespeople can be videoed in targeted communications.

Share our key messages via the Council’s and partners e-newsletters.

Fear and misinformation have contributed to the generation of myths around the origin and potential treatments of COVID-19. Where myths or conspiracy theories are circulating in communities or on social media, trusted sources of information will be shared to increase public awareness of facts and help prevent potentially dangerous behaviour i.e. 5G mobile networks do not spread COVID-19. Share WHO ‘myth-busters’: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/myth-busters

Promote announcements and press releases across all relevant digital channels.

Update the weekly Public Health dashboard with key information to help Somerset residents, businesses, visitors and communities make informed decisions.

Regularly update dedicated webpages (www.somerset.gv.uk/coronavirus and partners) with relevant information, advice, support and latest government guidance for residents, businesses and employers, and those shielding.

Depending on the severity and level of an outbreak, digital road signage could be used to promote key approved messages.

**7.6 Communications toolkits**

Develop a communications toolkit including ‘outbreak checklist’, stakeholder list, reactive statement, sample letter, links to government guidance etc, digital assets, which can be shared with Comms colleagues in advance of any outbreak.
Communication toolkits should be prepared for the following evidence-based potential ‘higher risk’ outbreak scenarios in the first instance:

- Care homes
- Workplaces
- Educational settings – early years, schools, residential settings
- Tourism sites – hotels, caravan sites, camping
- Hospitality and retail settings – pubs, restaurants, shops etc
- Faith centres
- Libraries
- Registration Services i.e. weddings
- Transport – public and school transport
- Village/Town/area

7.7 Internal communications

Messages should continue to be promoted via Somerset County Council and partners internal channels such as newsletters, staff briefings, Somerset Direct, Intranet sites, GP briefings, reception TV screens (if buildings open).

Key messages and resources should also be shared with partners to share with their own staff.

7.8 Publications

Continue to promote key messages through County Council and partner publications such as Your Somerset, VCSE, Communic8, The Loop, GP Bulletins.

Encourage evidence based ‘high risk settings’ to ensure posters and clear messaging is displayed at all times and they are clear on what to do if anyone within their establishment begins to show symptoms.

Additional publications will be required to support visitors to the area such as downloadable posters/leaflets for tourism/hospitality settings to display. These could emphasise Somerset’s elderly population, low number of cases in the area to date, the importance of keeping locals and visitors alike safe, abiding by social distancing rules and what to do if you or one of your party develops symptoms including relevant local health and support information i.e., single helpline.
8. Evaluation

Members of the COVID-19 Engagement Board will evaluate the effectiveness of whether this communications activity is succeeding in persuading people, visitors, employers and businesses to adopt appropriate behaviour to aid the pandemic management, with no community or sector left behind.

To inform this, regular evaluation will be measured and shared with the Board. This will include:

- A summary of communications activity
- Media coverage and tone
- Estimated reach of communications activity.
- Traffic for key webpages.
- Social media engagement and tone of comments
- Any feedback from stakeholders and residents on key messages.