Leicestershire County Council

HEALTH AND WELLBEING BOARD – 9 JULY 2020

CORONAVIRUS (COVID-19) IMPACT AND RESPONSE OF THE LOCAL CARE SYSTEM

SUPPLEMENTARY REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Purpose of the Report

1. This supplementary report advises the Health and Wellbeing Board on the impact of the Coronavirus (COVID-19) within the County and the initial response of the County Council and the local care system. The report also considers how the health and care system may develop as a result of the pandemic.

Recommendations

2. The Health and Wellbeing Board is asked to:

   a) Note the impact of COVID19 on Leicestershire's health and social care sector and the loss of life in the local area;

   b) Note the publication of the local outbreak and control plan for Leicestershire;

   c) Note the current situation in the protected zone of Leicester City and parts of Leicestershire.

Background

3. Coronaviruses are a family of viruses common across the world in animals and humans. Covid-19 is the illness seen in people infected with a new strain of coronavirus not previously seen in humans and began in Wuhan Province in China in December 2019. The first case in Leicestershire was reported on March 6th. Cases reached a peak in md-April. Although infection rates have fallen, they have not fallen as far, or as fast, as other areas, alongside the surge in cases in Leicester City, this represents a risk to the County, both now and in the medium term.

Health and Social Care Impact and response

Health

4. The initial phase of the NHS response to COVID - 19 commenced on 30th January with the declaration of a Level 4 National Incident. Following the World Health Organisation's declaration of a global pandemic on 12 March, on 17th March, the NHS initiated what has been described by NHS England and Improvement as the fastest and most far reaching repurposing of NHS services, staffing and capacity in its 72-year history.

5. This response has been unprecedented and necessary to deal with is one of the biggest international challenges faced in a generation. In Leicester, Leicestershire and Rutland (LLR) the total number of confirmed cases stood at 2,451 as at 24th June. Sadly 772 LLR residents have lost their lives, either in LLR hospitals or elsewhere.

6. The need to adapt and respond to the COVID - 19 epidemic has permeated all aspects of NHS services. As this paper highlights, to control the spread of the virus and protect patients, it has been necessary to temporarily redesign how some services are accessed and provided or, in some cases, pause services in the interests of protecting patients and staff, to focus on the anticipated demand to support COVID – 19 cases.

7. Overall, the NHS in LLR has coped well under intense pressure as we went through the peak period during April. All patients who needed intensive treatment and support received the care they needed.

9. The hard work and commitment of NHS staff and key workers in other agencies has been instrumental and should also be acknowledged. They have worked through the most challenging of periods with such high levels of dedication, professionalism and commitment to look after the people of Leicester, Leicestershire and Rutland.

10. It should be acknowledged that the public's positive response to social distancing guidance has also helped to protect the NHS.

Planning arrangements

11. NHS organisations began preparations for managing COVID - 19 in January 2020, setting up a Health Economy Tactical Coordination group (HETCG) to coordinate the health response in LLR.

12. On 24th March, the COVID–19 outbreak was declared a Level 4 national emergency and in response a Major Incident was declared locally. NHS arrangements were integrated within the LLR Local Resilience Forum (LRF) governance and incident management structure under the strategic leadership of Leicestershire Police.

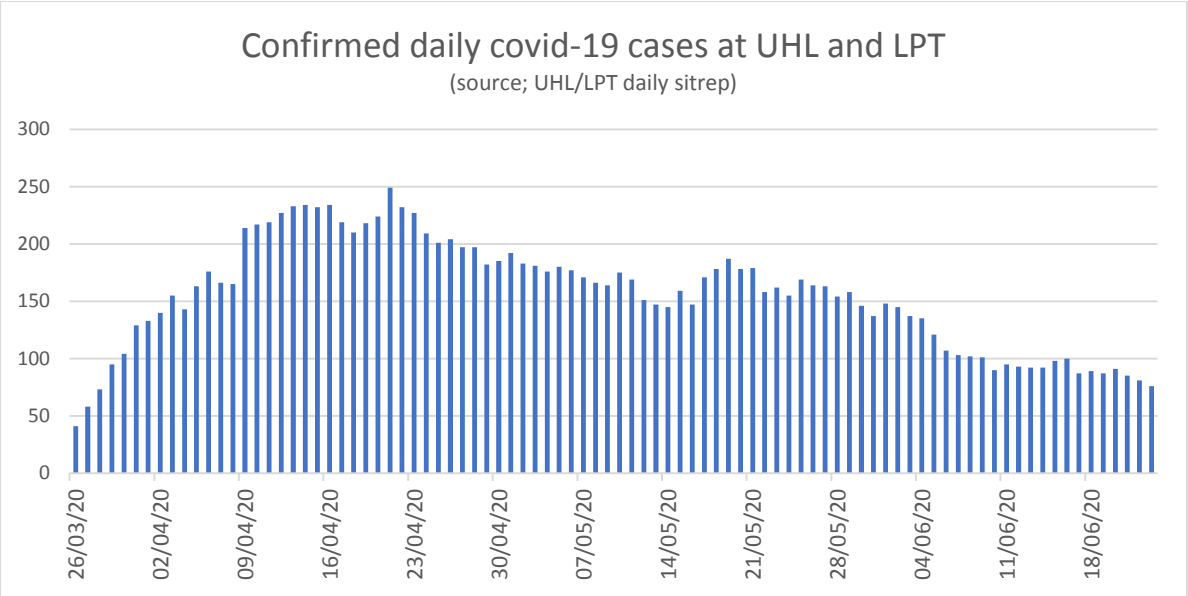
13. Within the LLR NHS the Health Economy Strategic Control Group (HESCG) has overall responsibility for the multi-agency management of the incident and to establish the policy and strategic framework within which lower tier command and coordinating groups work. Representatives on the HESCG are senior leaders within the NHS and other organisations including Local Authorities. It is chaired by the Chief Executive of the three LLR CCGs and the CEOs of other NHS organisations are also members.

14. The Health Economy Tactical Co-ordination Group (HETCG) is responsible for:

- Coordinating the preparation for, response to, and recovery from any outbreak of COVID - 19;
- Implementing the direction and guidance received from the HESCG, LLR CCGs, NHS England and Improvement Incident Management Centre; and
- Ensuring close partnership working with multi-agency partners through the LRF Tactical Coordination Group and the HESCG.

15. Supporting the HETCG are 13 tactical cells, each leading the operational response for an organisation or function/activity perspective.

16. The table below shows the number of confirmed daily cases in UHL and LPT. As can be seen the number of daily cases peaked from 9th April to 26th April when there was regularly between 200 and 250 patients.



17. The actions taken as a system and the efforts of colleagues directly providing care ensured capacity was maintained and not overwhelmed.

Actions taken by the local NHS partnership

18. Action taken by NHS organisations in the initial phase focussed on increasing capacity to prioritise care for COVID -19 patients and ensure guidance on infection prevention and control was strictly followed. This involved redesigning some services to ensure they could be delivered safely, protecting patients and staff through reductions in face to face contacts and consultations - including stepping up the use of technology, and suspending some elective services.

19. It should also be noted that despite these changes the NHS remained open to patients with non-COVID related emergencies or urgent care needs because of the measures being taken to separate COVID and non – COVID patients.

20 Specific examples of the actions taken include:

- Increasing critical care capacity in UHL. Critical care beds increased from 50 to 150, with the potential to create around 300 beds.

- Temporary changes to LRI's Adult's and Children's Emergency Departments at UHL. Now split into two separate areas: Blue department - for patients without symptoms of COVID - 19 and The Red Department - for patients with symptoms of COVID – 19.

- Health and social care working jointly to implement effective arrangements to ensure clinically fit patients can be safely discharged from hospital settings.

- In Leicestershire Partnership NHS Trust action was taken to increase community hospital in-patient capacity by up to 70% for step down patients and end of life care, including the phased introduction of 75 Independent sector beds and up to an extra 72 beds on additional LPT wards. Overall community beds could increase from 222 to around 350. More temporary changes are being undertaken in community inpatient facilities to establish additional capacity to meet any further COVID-19 related surge and create Covid secure wards

- Temporary changes to mental health services including: a new Mental Health Urgent Care Hub to assess urgent mental health patients to reduce demand at the emergency department at LRI; a Mental Health Central Access Point providing a24hour 7 day phone support for the public, including those who have not used mental health services before; and a new community based mental health rehabilitation offer to support people with longer term mental health illness outside of an inpatient setting

- Introduction of remote triage in GP practices (via telephone or online) and option of video or online consultations. This has enabled practices to continue to meet the needs of their patients and provide non-COVID - 19

related care, whilst reducing the risk of infection by minimising face to face contact. Currently all patients are remotely triaged and offered either telephone or video consultations and 65% are offered an online consultation.

- The restriction of visiting arrangements which we fully acknowledge was deeply upsetting for relatives and friends unable to visit their loved ones. Alternative arrangements were put in place for example the use of iPad to allow video calls to relatives on wards, and messaging/card services.

System Recovery

Ongoing incident management

21. At the time of writing the UK Government COVID - 19 Alert level is level 3. NHS England and Improvement has, however, determined that the NHS remains at level 4 for the purpose of ongoing management of the response.

22. Arrangements for incident management have been maintained, ensuring the NHS is in a strong position to respond to changes in the prevalence of COVID - 19 and the impact on NHS services. The joint working, particularly between health and social care, has supported more holistic approaches to decision – making, enabling rapid action to be taken to resolve problems, and in many cases creative solutions to long-standing challenges.

23. The NHS will continue to work closely with local authority colleagues as they develop outbreak plans. Close working with public health colleagues is essential to understand the prevalence of COVID -19 and the potential for further 'local hotspots.

24. This will include surge exercises to test the system ability to manage different scenarios over the coming months in addition to the normal surge planning events such as winter flu and bad weather.

25. Underpinning everything is the infection, prevention and control (IPC) position of NHS England which aims to ensure that no patient or staff member should catch COVID - 19 NHS healthcare facilities.

26. Like the general population, the NHS will be operating in a world with COVID - 19 for the foreseeable future.

27. For patients there are now requirements when attending hospital sites to wear face coverings. Visiting restrictions remain in place, but we will review them. NHS Trusts fully acknowledge the difficulties and distress this has caused but we need to continue to protect patients and the public.

28. All sites are undertaking risk assessments and audits to ensure they meet the rigorous standards for infection control and social distancing.

PPE

29. In LLR, the NHS has faced some challenges with the availability of PPE as was the case nationally. At times stocks of items ran low and it took some time before the supply process worked effectively.

30. Mutual aid within the NHS in LLR and with neighbouring Trusts in other areas resolved the situation when necessary but was clearly not sustainable. Once the national supply chain was working effectively, including a central portal for ordering, the situation has largely been resolved but maintaining vigilance on stocks and supplies is essential going forward.

Care homes

31. The joint working arrangements between health and social care has ensured robust support is available to care homes.

32. During the earlier stages of the outbreak it should be acknowledge that there were some significant challenges facing care homes including: discharge of patients without a negative COVID test, the availability of appropriate isolation facilities for caring for COVID - 19 infected patients, clinical support, shortages of PPE and resilience of staff and the impact of staff sickness.

33. To support care homes, health and social care have now established processes for the safe discharge of patients to care homes and support arrangements to ensure resilience in homes in response to staff shortages, for example. Training on Infection Prevention and Control and clinical leads to support care homes.

34. The joint working between health and social care to support care homes will continue as will ongoing monitoring of care home resilience.

Testing and tracing

35. The test and tracing service ensures that people who develop symptoms can be tested to find out if they have the virus, and also includes targeted asymptomatic testing of NHS and social care staff and care home residents.

36. It also helps trace close recent contacts of anyone who tests positive and, if necessary, notifies them that they must self-isolate at home to help stop the spread of the virus.

37. Tests are carried out at the testing centre set up at Birstall Park and Ride and through Mobile Testing Units (MTUs), visiting various sites around Leicester, Leicestershire and Rutland. UHL staff can also have the test at UHL.

38. The Birstall site has carried out 28,946 tests from 30th April to 21st June, whilst the MTUs have carried out 8,775 tests during the same period. From the 27th April to 21st June 1,728 staff have been tested for suspected COVID-19.

39. Whether symptomatic or not, all non - elective patients are given the test at the point of admission and elective patients are tested within 72 hours of being admitted.

40. We are at the beginning of the antibody testing programme to determine if someone has had COVID-19. The prioritisation and rollout plan for antibody testing is in line with national guidance and is currently available for NHS staff in UHL and LPT and primary care. There is an allocation of 1000 tests per day to cover these groups of staff and almost 12,248 UHL and LPT staff had been tested for antibodies to 21st June. On average 433 tests are carried out

41. We are working on extending antibody testing to the wider LRF partnership, including whole care home testing and considering options for home swabbing for surgery patients isolating for 14 days prior to surgery.

42. It should be noted that having an antibody test will only inform a person they have had COVID-19 and does not change the advice to self – isolate if they are in close contact with someone who has tested positive for COVID-19. There is currently no guarantee that having contracted COVID-19 a person is immune from future infection with COVID-19.

<u>Service recovery and restoration</u>

43 As stated above, the initial response was the need to deal with COVID - 19 related patients, and the action taken, including the cancellation of non-elective treatments and procedures, reflects this.

44. Within the next phase a ‘safe re-start’ of services stood down or reduced during the initial phase will be undertaken.

45. In line with the aim that no patient or staff member will catch COVID - 19 in our hospitals. The following are six key areas of action and priorities:

Meeting patient needs

- Covid treatment capacity: maintaining critical care infrastructure (workforce, estates, supply, medicines) that enables readiness for future covid demand, and managing the separation of COVID and non-COVID patients.

- Re-starting non-covid urgent care, cancer, screening, and immunisations, identifying the highest risk services that have had the most impact in terms of population health. This includes recovering service waiting lists and delayed referrals.

- Services have been prioritised including cancer, maternity, cardiovascular disease, heart attacks and strokes, mental health. There has clearly been an increase in the number and length of time people are waiting and the system is building a complete picture of the impact of this as an anticipated increase in GP referrals takes place.

- Addressing new priorities: the impact of COVID - 19 on public health including identifying additional needs due to the pandemic and considering health inequalities. This specifically includes responding to the clear evidence to have emerged on the disproportionate impact of COVID - 19 on the BAME community. We also anticipate increased demand for mental health services and support due to the economic consequences of COVID -19 such as increased unemployment for example.

- Staff capacity and wellbeing: including capitalising on new ways of working, considering staffing ratios and moving the current expanded workforce to a sustainable footing.

- Working jointly with LRF partners through the Health and Wellbeing Board (HWB) local resources for staff have been developed. The national resources (wellbeing apps) and support for resilience and counselling.

- Working closely with BAME colleagues within the NHS workforce to ensure we understand their concerns and respond to them. BAME colleagues must have the reassurance and confidence to feel safe carrying out their work. A programme of risk assessments and listening exercises has been undertaken and through the HWB specific resources have been developed for BAME staff.

Re-set to a new NHS

46. There is a need to retain acute, primary and community service innovations in future models of care. Work is ongoing to cataloguing the service delivery and clinical pathway changes that have worked to assess these in terms of retaining to share and develop further. Many of the changes implemented during the pandemic, where they demonstrate benefits to patients and are clinically and financially viable, should be retained.

47. Using an NHSE Impact Assessment Tool (IAT) services are being categorised as ‘restore’ or ‘recover’. The IAT, assesses each change for patient safety, clinical effectiveness, and patient outcomes. Where there are no clearly identifiable benefits the change is not viable, and the service will be restored to its pre-COVID position.

48. If the IAT identifies benefits and the service change is viable for consideration as a permanent change a further review is required to ensure it aligns with the long-term plan for health services in LLR.

49. The IAT process includes the need to engage with stakeholders, specifically OSCs, Healthwatch and the Care Quality Commission and will follow the NHS *Planning, assuring and delivering service change process. Changes will be consider in light of the long term and strategy for health services in LLR. Engagement with staff, public and other stakeholders will be undertaken where required.*

2. Social Care

50. In response to the pandemic and in accordance with legislative changes and government guidance for local authorities, Adult Social Care (ASC) services have been reviewed and amended to enable continued service delivery. A Covid Steering Group is in place with senior managers and business partners to oversee and lead the crisis response and escalation process. Sub cells of this group focus on key service delivery areas with activity data reported daily.

51. Recovery planning and actions are in place to embed new ways of working, enacted during this phase of the emergency, to restore prior services where appropriate, and to future proof service delivery where this can benefit both people who use our services and staff.

Impact of COVID19 on services

Provider market

52. Enhanced support for care homes and domiciliary care providers has been in place to provide advice and information, financial and practical support where appropriate. Daily contact and data collection have been undertaken to track activity and operational issues as they emerge. Overall 68 (36%) care homes in the county have reported an outbreak since March, and around 20% of care homes report they have residents currently isolated or symptomatic.

53. Increased mortality rates and reductions in admissions mainly from community and self-funding residents has led to average occupancy rates reducing to around 80%. Consideration is being given to provider stability given that in the longer term, low occupancy rates may compromise financial sustainability for care home businesses. Work is continuing to assist care homes to be able to isolate residents, restrict staff movement between homes, register and administer testing, access and utilise appropriate PPE, Infection control measures and clinical support.

54 Despite early issues in respect to PPE availability and concerns about workforce capacity, domiciliary care services have demonstrated good levels of resilience throughout this period. There are over 5500 people are reported to be currently receiving services in the county of whom less than 1% are confirmed to be COVID positive. There are 4585 staff working in home care

services of whom only 6.5% are absent due to COVID, although a quarter of providers report higher levels of absence

55. ASC has supported the sector with recruitment and training of staff resulting in over 130 new entrants, to ensure safety and capacity of care available. Reductions in community demand, prioritisation of services and support from families, friends and volunteers has ensured the market has remained stable with good capacity during this time.

56. Community and day services, and short breaks building-based services have been closed or significantly reduced because of social distancing and infection control measures. but services are being provided where needed in people's homes and to support access to some daily community activity and virtual support. Staff have been redeployed to support home-based care and carer support.

Hospital Discharge

57. Hospital discharge continues to be a significant area of focus with new Discharge Guidance issued in March 2020 to cover the Covid emergency period that is still in place. The requirement for timely discharge has been met by the introduction of a discharge hub model in place at the Leicester Royal Infirmary (LRI) which acts as a single point of access for all hospital discharge referrals including those from out of county hospitals. ASC has responsibility for arranging all discharge support with MDT triage and agreement.

58. Post discharge reviews are undertaken to ensure that people are in the most appropriate setting for recovery and that their support is maximising their opportunity for increased independence.

Prevention Services

59. ASC has been co-ordinating and providing assistance to the 25,000 clinically Vulnerable People identified as requiring shielding in Leicestershire, working closely with district and volunteer services to provide safe and well checks and practical support where needed. Over 14,400 people on the Shielding List are currently registered for support, of whom 5,183 are registered for support obtaining essential supplies and 1,176 registered with basic care needs. The County Council has made over 12,000 calls to people who have registered, and district councils have contacted an additional 8,800 people of those responding to say that they had existing food networks, and no identified care needs.

Workforce

60. Most staff have been enabled to work from home. Face to face visits have continued where appropriate with PPE as needed. Where possible, telephone or email assessments have been undertaken and services

commissioned to meet essential needs. Where services have been changed a review has been undertaken to ensure that people agree to the changes and remain safe.

61. ASC has used some allowed Care Act flexibilities to deliver services in a safe way but has not formally moved in to the easements that the new guidance allows re suspension of assessments and eligibility where service capacity is compromised by increased demands.

62. Care management has continued with regular checks and risk assessments for people with complex needs and MDT review of those most at risk. We have seen an increase of mental health and safeguarding referrals to teams reflecting the anxiety and uncertainty of the current situation. Several changes to normal practice have been needed during this episode to continue to operate safely and effectively as restrictions were put in place.

63. The Business As usual (BAU) cell was set up as a subgroup of the Covid response steering group and has provided guidance to staff and managers on the changes needed to continue to operate a good service response with the safety of staff and people who use services paramount. Audits and reviews of support plan changes have been put into practice to ensure appropriate compliance with new instructions during this emergency period.

64. Remote working has been implemented in all areas and where face to face contact has been appropriate, PPE and guidance on how to use this has been made available to staff.

Finance

65. The new discharge guidance issued means that all support packages that are put in place as a result of hospital discharge or prevention of hospital admission are deemed the responsibility of Health and therefore are currently being funded by the NHS via local CCGs.

66. This means that for now, people are receiving services that have not been assessed or reviewed in terms of social care or continuing health care eligibility. When the government agrees that emergency period ends, there will be a need to agree a method of transition to appropriate funding authorities and recommence financial assessment and people's contribution amounts to their support packages. The Council are aware of over 2000 support packages having been put in place since 19 March 2020.

67 In addition, extra social care funds have been made available to pay for the extra demands on social care providers to deliver safe care during this crisis. It is anticipated that the funds available will not cover the Covid cost that the Department has funded.

Recovery Planning

68. Recovery work so far includes collecting and collating changes made due to Covid impact and opportunities to embed best practice in the post-Covid service outcomes.

69. In total 115 changes have been noted and a series of deep dive workshops to explore areas of change and what the new normal should look like. Recovery actions ae being phased in line with government plans and links with other departments' and key organisations' recovery plans to ensure synergy and coherence. Further work will also be undertaken to ensure adherence with, or changes to the department's service outcomes and the Adults and Communities Strategy.

70. Our Principles of Recovery are:

- We will continue to drive forward our service principles of Promoting independence and strengthening resilience to enable people to get the best outcomes from our support.
- We will review our current models of service delivery and embed new practices that enhance our offer to people and staff
- We will future proof our resilience plans in line with our duties and powers to ensure a timely response to any further outbreaks or incidents
- We will listen to feedback from people and staff and use this to inform our practice
- We will support staff to deliver best outcomes and embrace new and creative ways of interacting with people, providing a good work life balance, with due regard to staff health and wellbeing
- We will help people to achieve improved independence by providing reablement services and Equipment / AT that reduces reliance on other people for activities of Daily Living
- We will work with our District and Health colleagues to provide pathways of care that align to our service outcomes and achieves a coordinated and integrated response
- We will look to secure the right accommodation and environments for people to maximise their opportunities for improvement and progression to an independent and fulfilling life
- We will build relationships with providers that enable us to deliver safe and meaningful services that support our service principles of improved independence
- We will use our expertise and knowledge to drive continuous improvements for our service delivery and performance
- We will build on the volunteer and community support networks built during the covid period to support our service outcomes for people

Opportunities

71. Significant practice and service delivery changes have been implemented in a very short space of time. New ways of working have been adopted and many services have been re-organised.

72. People in receipt of services have experienced a different set of service interventions and in some cases, this has had a positive impact on them which has led to opening discussions with providers about alternative models of care.
Service Users will be enabled to self–serve when finding out information and undertaking basic assessments to support their independence and are enabled to digitally engage with our services.

73. Delivery of preventative approaches to shielding vulnerable people with district councils and the voluntary sector has demonstrated an ability to share data and information, integrate service offers and provide a model of countywide and localised delivery

74. Improved joint working with health partners delivering integrated services has been experienced as staff have worked together to respond to Covid challenges. This has enabled timely hospital discharge and reduced delayed transfers of care.

75. Digital solutions will be the first point of call where they can be effectively utilised to prevent, reduce, and delay people's pathways into social care, or where they can be effectively utilised to meet care needs. Our working processes should prioritise digital solutions where they save staff time and money, and our service user records and data will be fully integrated with health as part of the place-based approach.

Challenges

Integrated pathways of care

76. Hospital discharge support has seen an increase in ASC resources to support rapid discharge and commissioning of health funded packages. If this increased level of responsibility and activity is to sustained there will need to be an agreed discharge model with partners going forward that aligns to the ASC principles of promoting independence and care in an ideal setting.

77. Current outcomes from the discharge hub have met the immediate need for speed, and the safety of discharge processes have improved; however people are often not receiving their optimum care package leading to longer term consequences of increased dependency and service costs that may have been avoided if people had access to appropriate support at the point of discharge. This has led to double the number of people entering short term care and half the number of people have commencing reablement at home, in comparison to the same period last year

78. Transition of the hospital discharge emergency support packages to the appropriate funding authority will need to be carefully managed to ensure that people have the right level of care post recovery and that they receive a financial assessment for ongoing social care support to agree their contribution to the costs. People will have been in receipt of free services for an extended period including those who would normally pay the full cost of their services.

79. CHC teams will have a considerable back log for DST and review. The risk of increased health and social care assessment and long term funding, if not carefully managed with joint agreement, is significant.

Provider Sustainability

80. The current provider market has been a key focus of ASC support as the availability of good quality, safe and affordable services is vital to ensure that we can continue to meet need. Recruitment, training, management and emergency planning, funding and access to PPE has been put in place.

81. Care homes have seen a perfect storm of increased costs in relation to workforce, IPC measures and purchase of PPE at the same time as seeing a rise in vacancies that may not return to pre-Covid levels. The current average occupancy is around 80% and considerably lower in some providers. The cost of care nationally through the COVID period have been estimated to be £6bn above current funding levels, and the care provider market has estimated that it may take many years for the market to stabilise. This may lead to a higher number of care providers exiting the market and ceasing provision over the sort to medium term

82. Domiciliary care providers have maintained and, in some cases, increased capacity but continue to struggle to recruit and retain staff. As hospital demand increases and community referrals return back to pre COVID levels it is likely that domiciliary care services will see demand outstripping capacity. This maybe compounded by changes in the expectations of families and the way the public use care services with less focus on residential services.

83. The system needs to recognise the joint responsibilities and interdependency of available and good quality social care support for all pathways of care to achieve the outcomes for people who use health and social care services. Joint commissioning of services ensures that we can deliver this as a system. Integration of care pathways needs to support the system-wide outcomes for people that leads to resilience, good health and wellbeing.

Leicestershire County Council Covid-19 Outbreak Control and Prevention Plan.

84. On 22nd May 2020 Government announced that as part of its national strategy to reduce infection from COVID-19 it would expect every area in

England to create a local Outbreak Plan. As the lead on local Public Health, Leicestershire County Council has developed its Local Plan, a copy of which has been published on the County Council's website and appended to this report. The Plan will be continuously reviewed and updated where required.

85. The aim of the Local Outbreak Plan is to protect the health of the population of Leicestershire from COVID-19. This will be done through the following objectives:

- Preventing the spread of COVID-19 and associated disease

- Early identification and proactive management of local outbreaks

- Co-ordination of capabilities across agencies and stakeholders

- To assure the public and stakeholders that this is being effectively delivered

86. The Plan is intended to enable agencies in Leicestershire to prevent, manage, reduce and suppress outbreaks of COVID-19 infection across the County. It sets out the arrangements for surveillance of and response to local outbreaks and infection rates. The Plan identifies aims, objectives and the appropriate governance and responsibilities for each of those. It details the support Public Health will provide to organisations in a range of settings and outlines what those organisations can do to support themselves in the event of an outbreak.

87. Accountability for the management of outbreaks of COVID-19 rests with the Director of Public Health and the County Council and the Plan includes the governance arrangements relied upon to manage local outbreaks. The governance structure includes the creation of an Outbreak Planning Board which will be responsible for the oversight of local outbreak control plans and outbreak management and a Political Oversight Board which will provide political ownership and public-facing engagement and communication for any required outbreak response. The County Council will continue to work with health partners and our colleagues in district councils to proactively manage any outbreaks.

Local Outbreak

88. On the evening of Monday 29th June, the Secretary of State for Health and Social Care announced the introduction of a local lockdown for Leicester City and parts of the surrounding County.

89. In response, the County Council worked with City Council colleagues and Public Health England to define the lockdown area, including the locations around the city boundary which could be affected by the virus spread. A map of the affected area was subsequently published by the County Council and can be found here. PHE has also produced a report which summaries the investigation into COVID-19 exceedances within the City during June 2020.

90. Before the announcement, the City Council was leading the response to the recent surge in recorded infections. Following the local lockdown, an instance management team was established and is being led by Public Health England's (PHE) Director in the West Midlands with the support from the City and County Council's Directors of Public Health. In addition, a comprehensive sub structure has been formed to manage various elements of the local response such as testing, support for those who need to continue to self-isolate, community engagement, communications and education.

91. Whilst recognising that the epicentre of the lockdown is in the City Centre, the County Council is working closely with PHE, the City Council and affected district councils to make certain that the appropriate resources and support is also available to County residents who are included in the lockdown.

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Equalities and Human Rights Implications

92. There are no equalities or human rights implications arising directly from the recommendations in this report.

93. The pandemic of the Covid-19 virus has required the Council and other partners to be flexible and responsive in the way in which it delivers its services and performs its functions. The Council's Corporate Equalities Board, together with Departmental Equality Groups will play a key role in monitoring the impact of any changes.

Appendix

Outbreak Control Plan and Appendices