Cheshire & Merseyside Contact Tracing, Outbreaks and Self Isolation Issues for Workplaces and Contact Tracing Issues in General

Liverpool, St Helens, Wirral, Sefton, Knowsley, Cheshire West and Chester, Cheshire East, Warrington and Halton.

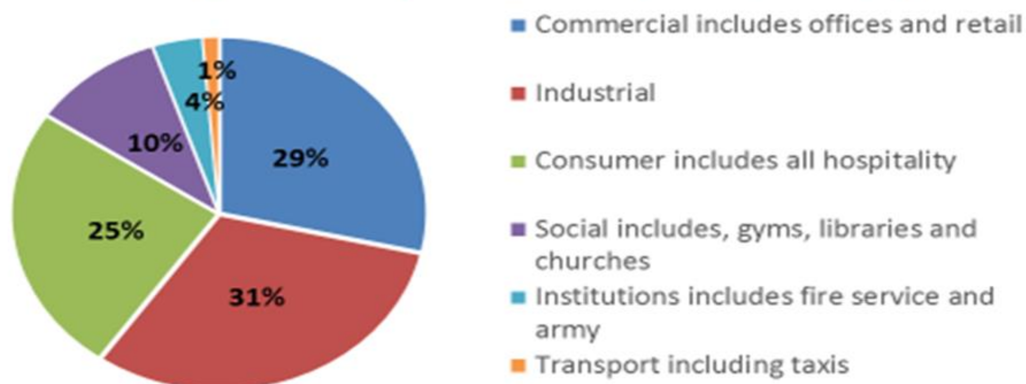
Background

Cheshire and Merseyside Public Health system has been working together during the COVID 19 pandemic to identify how we can improve contact tracing, testing, containment and engagement. This has included working with the national team to explore problems within CTAS and seek to address them. This has been met with varying levels of success. We would now like to revisit some of these issues and in particular look at COVID in the workplace where we are seeing a substantial increase in outbreaks.

During this 3rd wave of the pandemic employees are currently advised to work from home and if that is not possible employers and employees should strictly adhere to COVID secure conditions within the workplace and follow government guidelines on testing and self-isolation. This approach ultimately benefits businesses as it stops the spread across the workforce and allows work to continue. Cheshire and Merseyside is concerned that this is not happening consistently across the sub region. Numbers vary, but in a week, there are an average of 4 workplace outbreaks, requiring an Outbreak Control Team meeting, not including care homes, schools and supported living.

Focus on business – 77 outbreaks in 5 months.

Outbreaks* managed by Chester & Cheshire West Council's COVID-19 Outbreak Management Hub September 2020 – to present (Number, %)



*Includes outbreaks & some exposures in high risk settings
(77 outbreaks in total) (*excludes* all outbreaks in care homes, supported living and educational establishments)

Cheshire West and Chester

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Google mobility data for Cheshire and Merseyside shows that twice as many employees are now going into workplaces compared to the first lockdown in March. Local intelligence indicates employers are not always doing what they can to advise workers to self-isolate if they know they are a contact of a positive case. This is partly due to a reliance on the sometimes-flawed national CTAS system and partly due to employers wanting their workforce to stay in the workplace and not disrupt business.

In addition, Liverpool City Region, which includes 6 out of 9 local authorities in Cheshire and Merseyside, has high rates of manual and routine workers. Data from the 2019 Population Survey shows that up to 57% of working residents in LCR are employed in an occupational role where working from home would be difficult if not impossible. They are also disproportionately employed in low income, zero hours jobs where they are not always provided with sick pay. The self-isolation payment of £500 does not always cover their household expenses so they are more inclined to work if allowed by their employer (see case study attached).

The examples below offer real life situations local authorities in Cheshire and Merseyside are dealing with. They include large supermarket chains, national mail delivery outlets, multi-national companies and local businesses. We do also have an exemplary example of a company dealing with outbreaks in a very proactive, professional manner and include that as a case study.

Based on our findings we would recommend:

1. The CTAS system should be reviewed to ensure improved data capture and timely sharing with local and regional public health teams. Any national guidance to businesses should include the requirement of providing contact details including name, DOB, telephone numbers and emails to local authority public health teams for the purpose of being able to input into CTAS. This would enable contacts to be followed up to ensure isolating, welfare checks and support.

2. Guidance for employers on their role in contact tracing and self-isolation should be strengthened to encourage employers to proactively identify contacts of positive cases within the workplace. Employers need to be aware of the information they need to collect in the first instance. This helps to minimise follow up questions where information may have been lost in the passage of a few days. Examples include, travel to work, car sharing, changes to shift pattern/overtime that might fall out of the usual staff rota information that is available and so on.

3. CTAS should highlight that when people have a test, they are consenting to providing details of any contacts and therefore must co-operate with both national test and trace and local authority public health teams.

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4. Information on the use of PCR and LFD tests needs to be strengthened so that any necessary self-isolation rules are applied.

5. Consideration should be given to providing additional training and information to employers on what constitutes a contact and how to trace them. This needs to include how to promote honesty and when disciplinary action is advised.

6. Training and communications on symptoms and testing needs to include the household and not just the individual as some adverts just say "if you have symptoms" when they should say "if you or anyone in your household".

7. Employers should ensure that their employees are not missing out financially when asked to isolate due to being a contact through the workplace or household or community.

8. Businesses should be asked to check re. vehicle sharing, any second jobs and if employees are currently working from home or office based (and if so site details).

9. Piloting a One Team approach where Test, Trace and Self Isolation is run locally would offer a new approach with learning.

10. The new national BEIS scheme for self-testing by businesses with over 250 staff should liaise more closely with local authorities so we have sight of which companies have been invited and can support them to set up a robust scheme.

11. Employees should be enabled through enhanced communications to understand that they have a responsibility to know and follow the self-isolation rules and to understand if their employer is asking them to do something that is wrong.

Cheshire & Merseyside Examples:

Local authority level contact tracing and outbreak management have identified related issues in the operation of contact tracing and outbreak management that is compromising the prompt investigation and resolution of workplace outbreaks. We are seeing:

1. **Contact tracing and self-isolation**

Many companies including large multi-nationals have initially advised public health professionals investigating outbreaks that they rely on the national track and trace system to identify workplace contacts of positive cases and do not proactively identify potential workplace contacts themselves.

There are a number of issues related to relying on CTAS to identify and notify workplace contacts:

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- There is an assumption that the national track and trace system will identify the workplace of the index case– for the reasons set out in point 2 below this is often not the case.

- If the workplace is identified there is then an assumption the case will declare all contacts and will know the names and contact details for all their contacts. In a large workplace with temporary or agency workers this may not be the case. The case may also not understand the definition of what a contact is unless explained to them.

- If the case does identify the workplace and all contacts, there will be a delay of around 24-48 hours between the initial case testing positive and being contacted by CTAS and providing contact details and then a further delay of between 24 and 48 hours for those contacts to be contacted by CTAS and instructed to self-isolate.

- It is possible the NHS contact tracing app could identify workplace contacts, however, this assumes the employee has downloaded it and uses it.

- There have also been numerous reports that employers have instructed employees to turn the app off to avoid them being identified as contacts without putting an alternative system in place.

- Some employers routinely ask staff to leave their phones in a locker while on the shop floor.

- Some employers are also relying on testing, both LFD and PCR to ensure workplace contacts of a positive case remain in work. Contacts of a positive case are told by employers to obtain a test and they are instructed to return to work if it comes back negative when they should be self-isolating. Also, some employees are worried about repercussions such as disciplinary action or financial loss through isolating so may be reluctant to be honest about their contacts.

- There have also been instances when people have attended work whilst symptomatic or a household member is symptomatic and or whist waiting for test results.

Specific examples from C&M public health teams:

- A call centre operated by a large multi-national retailer, including a financial services division, was subject to a large outbreak and initially advised it relied on the NHS contact tracing app. They did not believe it was necessary to conduct any further contact tracing to identify contacts. They eventually co-operated with public health advice provided by an outbreak control team and have now adopted their own internal contact tracing procedure following public health advice and are asking contacts to self-isolate. There has been a big drop in cases.

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- A plumber’s merchant who had a COVID positive worker in close proximity to his colleagues sent his staff for asymptomatic tests and told them to return to work if negative.
- Larger employer with their own LFT system in place asked close contacts of positive cases to use the private on-site testing service and not self-isolate.
- Businesses not employing contact tracing in their workplace until there are multiple cases and outbreak situations. They are relying on the national system to identify contacts – despite us working with them to raise awareness of the importance of on-site contact tracing at the earliest stage.
- Also highlighted below are examples of workplaces informing cases they don’t need to provide their contacts information to CTAS as the employer already knows who those people are and “they are dealing with it”.

Existing guidance is not sufficiently robust on encouraging workplace contact tracing.

There is existing guidance for employers on NHS test and trace in the workplace.

https://www.gov.uk/guidance/nhs-test-and-trace-workplace-guidance#history

The emphasis in this guidance is on what to do if an employee is contacted by NHS track and trace. It also assumes the contact tracing information will be accurate and complete. It advises that:

> *“…Where those close contacts are co-workers, the person who has developed symptoms should consider asking their employer to alert those co-workers”.*

However, the guidance does not encourage the employer to pro-actively identify contacts of positive cases and require them to isolate.

Further guidance entitled:

Maintaining records of staff, customers and visitors to support NHS Test and Trace

This guidance actively discourages employers from contacting potential contacts and places the onus on the employee to provide the information to national track and trace.

> *“If a staff member, customer or visitor tells you they have tested positive for COVID-19, you should tell them to stay at home and self-isolate as soon as possible (along with the rest of their household) and encourage the individual to inform NHS Test and Trace of their recent contacts. You must not use the information you have collected to contact people”.*

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This may be appropriate for customers or visitors but not employees who are a contact of a co-worker.

Recommendation:

Guidance for employers on contact tracing and self-isolation should be strengthened to encourage employers to proactively identify contacts of positive cases within the workplace.

2. Inadequate workplace information obtained

It is apparent from the daily lines lists received for cases and contacts, and the subsequent local contact tracing work undertaken by public health teams, that inadequate information on workplaces and workplace contacts is being obtained at the initial stage of the national contact tracing system.

Workplace outbreaks are only being identified at a local level after enhanced contact tracing by local authorities and in some cases after notification by concerned employees. The regional contact tracing and outbreak management hub is also identifying workplace outbreaks if there is sufficient information available from the national system on common exposures. However, there is sometimes a delay in that information being passed on to the local public health teams.

Examples of workplace and other CTAS issues

- Out of 1300 CTAS calls from 15/01/2021 to 24/01/2021, listed for a Cheshire and Mersey Local Authority, 250 were found to have no data filled in for contacts.

- 163 of the 1300 did not have a postcode or area. The LA contact tracing team was therefore unable to link cases to identify outbreaks or in some cases even identify the businesses affected.

- Given the LA contact tracing team could not identify the business, nor the occupation of the cases sent to them it was impossible to assess the level of risk of a case in those workplace settings. This is important as, for example, one case in Daresbury Sci Tech can trigger significant intervention from the public health team and wider supporting organisations.

- In that same period there were cases from a large multi-national distribution company with no address. The LA knew there was an ongoing outbreak at one of their sites. They did not know whether it was the site they had been supporting or a new site.

- Index cases are able to complete the CTAS questionnaire online leaving household members, work and activities blank by clicking - ***no contacts to add, don't***

work/haven't done any activities, if they don't want to disclose information. Once the LA contact tracing team queries this with the case they usually provide the information. Can CTAS follow up more closely and query when people write No Contacts?

- One index case this week was part of the Oxford Astra Zeneca Trial and had tested positive on 16th January. The research team informed CTAS and provided the participants phone number and email address but she only received a letter from CTAS on 22nd January dated 19th January, advising her of her status. During this 7 day period she had not been self-isolating and had visited her elderly parents.

- Since recent changes to CTAS, their tracers are now unable to assign cases to themselves from another tracer without agreement from a supervisor. So, on incoming calls, unless a supervisor is available, the tracer cannot pick up the calls of a colleague if they have had to leave. The tracer must inform the caller they will be called back. Sometimes these callers do not pick up when subsequently called back.

- When completing the CTAS form the question: "how did you travel to work?" or "how did you travel to the supermarket?" is not asked. Travel option is classed as an 'activity' but cases completing online would not know this as there is no wording or instructions on CTAS to inform them.

- The CTAS form is too lengthy and requires inputting repetitive information rather than it being carried forward into fields, e.g. once you enter workplace you have to re-enter it again for later dates rather than "is this the workplace already entered?". Cases report giving up as it becomes too tedious.

- CTAS are sending some cases that are long term hospital patients e.g., a case this week has been in hospital for 3 months and was tested whilst an inpatient.

- There are system issues e.g. *page not found* message after updating each status, cases not showing on CSV file so having to check Power BI.

Recommendation:

The CTAS system should be reviewed to ensure improved data capture and sharing with local and regional public health teams.

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Appendix

An Example of Good Workplace Practice

Case Study - Bentley Motors, Cheshire East

Bentley Motors has established a coordinated package of measures to reduce the transmission of COVID 19. This has included all the standard measures to enable social distancing; promote hand hygiene and appropriate use of face coverings. In addition, the company has established its own COVID testing regime.

Testing

Bentley Motors established its own COVID testing centre as part of the company's business continuity plan. The firm has commissioned a commercial occupational health provider to run an on-site testing facility at its Head Quarters on the outskirts of Crewe. The facility is similar to the current model of Local Testing Sites commissioned by DHSC. It is located close to the main entrance to the site. Its hours of operation are aligned to the factory's shift patterns. It is worth noting that this facility was established some months before the national model of Local Testing Sites was introduced. The initial testing model utilised PCR kits. The company is working with the local authority with the introduction of LFT kits.

In broad terms there are two main testing regimes within the company.

1. Reactive testing: If an employee feels unwell at work he/she can receive a test at the on-site centre.

2. Proactive testing: Employees can be asked to take a test in certain circumstances, e.g. a return from foreign travel. (N.B. Bentley is owned by a German Company and there is a regular exchange of staff between the headquarters in Brunswick and Crewe. Also, the factory closed down for two weeks during the summer and all employees who travelled overseas were asked to take a test on return to work.

Outbreak Management

Led by its occupational health and safety team, the company has a proactive approach to managing possible and actual cases of COVID 19. The team has established a contact tracing programme to enable it to follow up any staff members who may have been close contacts of a member of staff testing positive.

As part of its programme staff members who are required to self-isolate have their work pass suspended until they have completed the full period. This prevents staff members returning to work before the agreed date. The Occupational Health Team maintain contact with such staff and review their fitness to return to work.

The Occupational Health Team keep a high standard of records which has enabled the Local Authority's Public Health and Regulatory Services Teams to have confidence in the company's contact tracing system. Occupational Health staff maintain contact with the Local Authority. In addition, the company has offered assistance in the borough wide COVID prevention programme, ranging from storage of equipment to delivering supplies and providing volunteers to assist vulnerable people.

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Case Study - Deprivation and financial inequality/poverty, CEVs and work in Knowsley

As measured by the 2019 Index of Multiple Deprivation, Knowsley is the second most deprived borough in England (out of 326 local authority districts) and the second most deprived in terms of the health of the population. Within Knowsley, 38% of Lower Super Output Areas are within the 5% most deprived in England. Over a third (37.27%) of all CEV's live in areas of the borough that are more than twice the national levels of deprivation.

Alongside the health deprivation factor, deprivation is also driven by income and employment. Average earnings for residents in **Knowsley have been consistently below the England average and are currently £76 per week below the average earnings for England. This means over the course of a year a Knowsley resident earns 15% less than the England average (at a value of almost £5,000).**

The latest ONS estimates indicate that around one in five (20.6%) working residents in Knowsley earn below the real Living Wage (as set by the Living Wage Foundation) of £9.30 per hour. This compares with 20% across England. Low wages are compounded by unstable or irregular patterns of employment. The number of people employed on zero-hour contracts across the UK has increased markedly in the last ten years from 0.6% of all jobs to a current estimate of 3.2% - this is likely to have increased further as a result of the economic impact on the labour market of COVID 19. Whilst local data for zero-hour contracts in not available, a broad approximation suggests at least 2,300 residents will be employed on zero-hour contracts – though likely to be higher based on there being more residents employed in lower occupational groups (such as elementary and caring, leisure and service occupations) where zero-hour contracts tend to be more common.

At the household level, income inequalities increase, and according to CACI household income estimates, average household income in Knowsley is approximately £30,400 compared with £38,700 across the UK – a difference of 22%. According to CACI Acorn segmentation, 60% of households in the borough fall into the two most financially stretched categories of 'Urban Adversity' or 'Financially Stretched' compared to 42% of households across the UK.

As a result of the level of deprivation in the borough, more people face financial hardship and there is greater dependence on the public sector to provide support.

Knowsley demand for support in First wave from CEV

In the period March to August 2020, 1,600 food parcels were being delivered per week to CEV residents in Knowsley. This was 1,000 from the National Government scheme and 600 being provided locally. In addition, 800 medication deliveries were made and 50 check in and chat calls were being undertaken weekly. The volume of food parcels being delivered is reflective of general levels of deprivation, income inequality and food poverty for the region which were further exasperated by the loss of income experienced by CEV during the period.

The costs to the Council of supporting this volume of CEV people, in food parcels alone, would cost £179,000 for a 4 week period. This also does not include the demand from wider vulnerable groups and those who also need to self-isolate.

Cheshire & Merseyside Directors of Public Health – 8th February 2021

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